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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

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In re:

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

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PLAN ADMINISTRATOR'S EIGHTH OMNIBUS OBJECTION TO ALLOWANCE OF CERTAIN ADMINISTRATIVE PROOFS OF CLAIM (Late Filed Claims)

Monica Terrano, as Plan Administrator (the "Plan Administrator") for the estate of Sound Shore Medical Center of Westchester, and its affiliated debtors (collectively, the "Estates"), by and through her counsel, hereby moves this Court (the "Eighth Objection") for entry of an Order pursuant to 11 USC § 502 and Fed. R. Bankr. P. 3007 disallowing and expunging certain administrative proofs of claim identified on Exhibit A annexed hereto on the basis that such claims were untimely filed:

[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.

Background

1. On May 29, 2013 (the "Petition Date"), 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. 67]. The Committee has 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. 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 filed as of November 25, 2015 (the "Governmental Bar Date" and collectively with the Bar Date, the "Bar Date"). On August 13, 2013, the Debtors caused written notice of the Bar Date, along with the Notice of Deadline Requiring Filing Proofs of Claim (Including Claims Under Sections 503(b)(9)) of the Bankruptcy Code (the "Notice of Deadline") 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].

5. 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].

6. 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 Debtors' estates.

7. 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

8. 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 3002 and 3007 of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules").

Relief Requested

9. Since the passing of the Administrative Bar Date, Plan Administrator, together with the Estate, and its counsel and advisors, have conducted a review of all filed Proofs of Claim (including any supporting documentation), along with the Estate's books and records to identify objectionable claims. As a result of the review, numerous objectionable claims have been uncovered which are addressed by this Eighth Objection. The claims that are the subject of this Eighth Objection are those claims which were filed after the passing of the Administrative Bar Date. The Plan Administrator is thus seeking entry of an order disallowing and expunging from the claims register each of the untimely filed claims.

Basis for Relief Requested

10. The Plan Administrator seeks entry of an order or orders pursuant to Section 502 of the Bankruptcy Code and Rule 3007 of the Federal Rules of Bankruptcy Procedure disallowing and expunging the claims identified in Exhibit A and attached hereto on the basis that such claims were untimely filed after the Administrative Bar Date.

11. 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).

12. Bankruptcy Rule 3007 provides, in relevant part:

> (a) An objection to allowance of a claim shall be in writing and filed. A copy of the objection with notice of the hearing thereon shall be mailed or otherwise delivered to the claimant, the debtor or debtor in possession and the trustee at least 30 days prior to the hearing.
>
> (d) Subject to subdivisions (e), objections to more than one claim may be joined in an omnibus objection if all the claims were field by the same entity, or the objections are based solely on the grounds that the claims should be disallowed, in whole or in part, because:
>
> (4) they were not timely filed.

13. 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 (the "Late Filed Administrative Claims"), each of which seek administrative priority, were filed after the Administrative Bar Date and should be disallowed and expunged. The Plan Administrator thus seeks to disallow and expunge all such claims on the basis that they were filed after the Administrative Bar Date, and as identified on Exhibit A hereto. The exhibit annexed hereto sets forth (i) the name and address of each claimant whose proof of claim is the subject of this Objection, (ii) the claim number as reflected on the Official Claims Register maintained by GCG, (iii) the date such claim was filed and (iv) the amount asserted in each proof of claim sought to be expunged.

14. The Administrative Bar Date Order provides, in relevant part, as follows:

> Each and every holder of an Administrative Claim, against the Debtors who, by this Order, is required to file an Administrative Claim as set forth herein, but who fails to properly file such administrative claim before the Administrative Bar Date, with proper supporting documentation: (i) will be forever barred, estopped and enjoined from asserting such claim against the Debtors, their estates or their property, and the Debtors' estates shall be forever discharged from any and all indebtedness or liability with respect to such claim, and (ii) shall not be treated as the holder of an Administrative Claim against the Debtors for the purpose of receiving any distribution under any plan of liquidation that may be proposed and confirmed in these cases.

See Administrative Bar Date Order, ¶ 4.

15. Allowing the Late Filed Claims, a) without a showing of any cause (*i.e.* excusable neglect) by the holders of such claims or b) with insufficient justification shown by the holders of such claims, could signal an inappropriate opportunity for other creditors to seek authority to file other late claims without showing cause. To allow the Late Filed Claims would be to the detriment of the holders of Claims who complied with both the Administrative Bar Date Order and General Bar Date Order and timely filed their Claim by reducing the ultimate distribution to the holders of such Claims.

16. Based on the foregoing, the Late Filed Claims should be disallowed and expunged.

Reservation of Rights

17. The Plan Administrator reserves all rights to object to any surviving claims identified on the annexed exhibit, whether scheduled or filed, and whether asserted or unasserted by any of the claimants affected by the Eighth Objection against the Estate. Should one or more of the objections in this Eighth Objection 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

18. Notice of this Eighth Objection will be given by mailing a copy of this Eighth 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 the respective addresses set forth on such exhibit, and (iv) each of the entities who have filed a notice of appearance in accordance with Bankruptcy Rule 2002. The Plan Administrator submits that such notice is sufficient under the circumstances and no other or further notice need be provided.

19. No previous request for the relief sought has been made by the Plan Administrator to this or any other Court.

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 B, and grant such other and further relief as is just and proper.

Dated: Great Neck, New York
June __, 2015

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

By: _____
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Afsheen A. Shah
Adam T. Berkowitz
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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

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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 EIGHTH 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 "Estate"). In my capacity as the PA, I am authorized to submit this declaration (the "Declaration") in support of the Estates' Eighth Omnibus Objection to Claims (the "Eighth 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 Second 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 "Administrative 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 Administrative Proof of Claim and determined that the claims covered by the Eighth Objection were objectionable. Throughout the process, I regularly interfaced with the Estates' professionals and advisors to address potential legal issues impacting each claim.

THE LATE FILED CLAIMS

5. I am generally familiar with the information contained in the Eighth Objection. Based on my review of the Administrative Proofs of Claim, I assisted the Estates' bankruptcy counsel in the preparation of the Eighth Objection and related schedules by identifying all filed administrative claims that were duplicative of earlier filed administrative claims (the "Late Filed Administrative Claims").

6. In evaluating the Late Filed/Administrative Claims, my advisors and I performed an in-depth review of the filed administrative claims (including supporting documentation) and determined that the claims that are subject to the Eighth Objection were untimely filed after the passing of the Administrative Bar Date. Therefore, I believe that disallowance, expungement, reclassification, reduction, or modification of each Late Filed Administrative Claim, for the reasons set forth in the Eighth 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 - Late Filed 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	ACUMED LLC ATTN ACCOUNTS RECEIVABLE 4860 NW BROOKWOOD PKWY HILLSBORO, OR 97124	1474	03/18/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $8,355.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
2	ALTAREJOS, TERESITA A 50 GUION PL APT 5E NEW ROCHELLE, NY 10801	1346	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $40,279.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
3	ATLAS PARTY RENTALS 554 S COLUMBUS AVE MOUNT VERNON, NY 10550	1471	03/04/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $1,639.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
4	BERCHTOLD CORPORATION 1950 HANAHAN RD CHARLESTON, SC 29406	1352	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $1,349.50	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
5	BOWEN, STEPHEN 37 ROCHELLE PL NEW ROCHELLE, NY 10801	1484	04/16/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $25,000.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
6	CALABRIA SOCIETY 81 UNION AVE NEW ROCHELLE, NY 10801	1486	04/29/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $1,100.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
7	CONKLIN, BARBARA 59 EMERSON AVE NEW ROCHELLE, NY 10801	1351	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
8	CORBETT, GERARD PO BOX 608 BRONX, NY 10465	1349	02/03/14	Howe Avenue Nursing Home, Inc.	13-22842	Admin: $300.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
9	CORNELL, HERBERT 677 S 7TH AVE MT VERNON, NY 10550	1500	03/28/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $4,000.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.

Sound Shore Medical Center of Westchester, *et al.*,
Exhibit A - Late Filed 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
10	CORON, ROGER 37 CARRINGTON DR GREENWICH, CT 06831	1493	05/27/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $24,989.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
11	DIVERSIFIED INFORMATION TECHNOLOGIES INC ATTN JULIE CALABRO 123 WYOMING AVE SCRANTON, PA 18503	1466	02/22/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $1,352.52	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
12	F WILLIA DAVIS WOMEN'S CLUB PO BOX 1594 NEW ROCHELLE, NY 10801	1478	03/31/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $1,000.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
13	FREEDOM MEDICAL INC ATTN NEIL EISENBERG - CORP CR MGR 219 WELSH POOL RD EXTON, PA 19391	1487	04/29/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $14,461.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
14	FREEDOM MEDICAL INC ATTN NEIL EISENBERG, CORP CREDIT MGR 219 WELSH POOL RD EXTON, PA 19391	1528	12/12/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $14,461.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
15	HEINEGG, PHILIP 1890 PALMER AV LARCHMONT, NY 10538	1464	02/14/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $8,000.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
16	JARVIS, TEMECA 4127 WICKHAM AVE BRONX, NY 10466	1350	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Unliquidated	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
17	JC EHRLICH PEST CONTROL PO BOX 13848 READING, PA 19610	1499	06/16/14	NRHMC Services Corporation	13-22845	Admin: $292.62	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
18	LEXISNEXIS 9443 SPRINGBORO PIKE MIAMISBURG, OH 45342	1501	04/14/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $3,873.62	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.

Sound Shore Medical Center of Westchester, *et al.*,
Exhibit A - Late Filed 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
19	LINDE/LIFEGAS ATTN CHRISTIAN HOBBIS, SR CREDIT ANALYST 575 MOUNTAIN AVE MURRY HILL, NJ 07974	1475	03/20/14	The M.V.H. Corporation	13-22843	Admin: $45,234.42	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
20	MARRERO, LISA A 30 HARVARD CT WHITE PLAINS, NY 10605	1488	05/01/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $26,319.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
21	MARTAB MEDICAL 40 BOROLINE RD ALLENDALE, NJ 07401	1458	02/11/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $2,450.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
22	MODERN MEDICAL SYSTEMS CO C/O ARENT FOX LLP ATTN ROBERT M HIRSH, ESQ 1675 BROADWAY NEW YORK, NY 10019	1356	02/03/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $30,406.98	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
23	MODERN MEDICAL SYSTEMS CO C/O ARENT FOX LLP ATTN ROBERT M HIRSH, ESQ 1675 BROADWAY NEW YORK, NY 10019	1357	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $69,838.64	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
24	NATIONAL DUST CONTROL SERVICES CORP 200 BLACKFORD AVE MIDDLESEX, NJ 08846	1354	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $5,370.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
25	NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL C/O NYS ATTORNEY GENERAL ATTN ENID NAGLER STUART 120 BROADWAY 24TH FL NEW YORK, NY 10271	1534	01/08/15	The Mount Vernon Hospital, Inc.	13-22840	Admin: $6,214.71	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
26	OCEANSIDE INSTITUTIONAL INDUSTRIES INC 2525 LONG BEACH RD OCEANSIDE, NY 11572	1345	02/01/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $17,482.29	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.

Sound Shore Medical Center of Westchester, *et al.*,
Exhibit A - Late Filed 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
27	OCEANSIDE INSTITUTIONAL INDUSTRIES INC 2525 LONG BEACH RD OCEANSIDE, NY 11572	1344	02/01/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $5,266.32	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
28	OCEANSIDE INSTITUTIONAL INDUSTRIES INC 2525 LONG BEACH RD OCEANSIDE, NY 11572	1343	02/01/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $12,137.04	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
29	OLYMPUS AMERICA INC 3500 CORPORATE PKWY CENTER VALLEY, PA 18034	1362	02/05/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $2,000.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
30	ORTHOSONICS LIMITED ATTN BRENT ALLDREDGE, ESQ 3451 PLANO PKWY LEWISVILLE, TX 75056	1347	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $2,700.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
31	POMCO INC 2425 JAMES ST SYRACUSE, NY 13206	1465	02/22/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $55,989.13	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
32	REID, LORNA A 15 SCHUDY PL NEW ROCHELLE, NY 10801	1460	02/13/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $93,174.35*	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
33	REID, LORNA A 15 SCHUDY PL NEW ROCHELLE, NY 10801	1461	02/13/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $93,174.35*	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
34	REID, LORNA A 15 SCHUDY PL NEW ROCHELLE, NY 10801	1462	02/13/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $93,174.35*	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
35	SIMPSON, ANNAMARIE 241 S 9TH AVE APT 3K MT VERNON, NY 10580	1361	02/05/14	Howe Avenue Nursing Home, Inc.	13-22842	Unliquidated	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.

Sound Shore Medical Center of Westchester, *et al.*,
Exhibit A - Late Filed 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
36	TRANSCARE AMBULANCE ATTN ABRAHAM AZAR ONE METROTECH CENTER 20TH FL BROOKLYN, NY 11201	1480	04/07/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $15,578.69	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
37	TRANSCARE AMBULANCE ATTN ABRAHAM AZAR ONE METROTECH CENTER 20TH FL BROOKLYN, NY 11201	1481	04/07/14	Howe Avenue Nursing Home, Inc.	13-22842	Admin: $385.54	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
38	TRANSCARE AMBULANCE ATTN ABRAHAM AZAR ONE METROTECH CENTER 20TH FL BROOKLYN, NY 11201	1482	04/07/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $1,488.66	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
39	TURIANO, JOAN 342 UNION AVE NEW ROCHELLE, NY 10801	1470	02/28/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $48,420.13	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
40	UNITED HEALTHCARE/EXECUTIVE HEALTH RESOURCES INC ATTN RACHEL A SMITH, CDM, UHC BANKRUPTCY LEGAL SERVICES SPECIALIST 185 ASYLUM ST 3RD FL - 03B HARTFORD, CT 06103	1359	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $22,438.79	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
41	UNITED HEALTHCARE/EXECUTIVE HEALTH RESOURCES INC ATTN RACHEL A SMITH, CDM, UHC BANKRUPTCY LEGAL SERVICES SPECIALIST 185 ASYLUM ST 3RD FR - 03B HARTFORD, CT 06103	1358	02/03/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $5,127.50	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
42	UNITED STEEL PRODUCTS INC 33-40 127TH PL FLUSHING, NY 11368	1363	02/07/14	The Mount Vernon Hospital, Inc.	13-22841	Admin: $420.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
43	VANDIS INC 1 ALBERTSON AVE STE 1 ALBERTSON, NY 11507	1348	02/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $12,279.75	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
44	WYCHE, DENISE M 80 GUION PL APT 12W NEW ROCHELLE, NY 10801	1479	04/03/14	Sound Shore Medical Center of Westchester	13-22840	Admin: $3,853.82	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.

Sound Shore Medical Center of Westchester, *et al.,*
Exhibit A - Late Filed 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
45	YOGA FOR BUSINESS INC PO BOX 138 MT TREMPER, NY 12457	1463	02/14/14	Howe Avenue Nursing Home, Inc.	13-22842	Admin: $475.00	Admin: $0.00	Administrative claim filed after the January 31, 2014 claims bar date.
* 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/aHelen 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)
ACUMED 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. MAR 18 2014

Name and Addresses Where Notices Should be Sent:
4860 NW BROOKWOOD PKWY.
HILLSBORO, OR 97124
ATTN: ACCOUNTS RECEIVABLE

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. $ 8,355.00 (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: Rachelle Bial
Title: Controller
Company: Acumed

Rachelle Bial (Signature) 3/14/2014 (Date)

Address and telephone number (if different from notice address above):

Telephone number. _____ 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 - 01474
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

acumed®

Invoice
PAST DUE

5885 NW Cornelius Pass Road
Hillsboro, OR 97124
TOLL FREE (888) 627-9957 FAX 1-888-821-3495
PHONE (503) 627-9957 EMAIL businessservices@acumed.net

Remit All Payments to
Acumed LLC
7995 Collection Center Drive
Chicago, IL 60693

Bill to

***SOUND SHORE HOSPITAL**
COD
16 GUION PLACE
NEW ROCHELLE NY 10802
VAT Reg:

Ship to

SOUND SHORE HOSPITAL
ATTN: RECEIVING
16 GUION PLACE
NEW ROCHELLE NY 10802

Information

Invoice Number	90400551
Billing Date	07/12/2013
Sold to	103151
Customer PO	NR177848
Packing List Number	80640151
Sales Order Number	368548
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	06/13/2013
Patient Name	GONZALEZ
Doctor Name	BERENFELD
Due Date	08/11/2013
Tracking Number	796222345525

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0010	PL-DR50L Acu-Loc® VDR Plate, Standard, Left Batch: 299795	1 EA	949.00	949.00
0020	CO-3100 3.5mm X 10.0mm Cortical Screw Batch: 300202	1 EA	77.00	77.00
0030	CO-3120 3.5mm X 12.0mm Cortical Screw Batch: 300812	2 EA	77.00	154.00
0040	COL-3120 3.5mm x 12.0mm Locking Cortical Screw Batch: 301739	1 EA	118.00	118.00
0050	CO-T2314 2.3mm X 14mm Locking Cortical Screw Batch: 298593	2 EA	104.00	208.00
0060	CO-T2318 2.3mm X 18mm Locking Cortical Screw Batch: 295509	4 EA	104.00	416.00
0070	CO-T2320 2.3mm X 20mm Locking Cortical Screw Batch: 299347	2 EA	104 00	208.00
0080	CO-T2322 2.3mm X 22mm Locking Cortical Screw Batch: 300102	2 EA	104.00	208.00

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ATTN: RECEIVING
16 GUION PLACE
NEW ROCHELLE NY 10802

Information

Invoice Number	90400551
Billing Date	07/12/2013
Sold to	103151
Customer PO	NR177848
Packing List Number	80640151
Sales Order Number	368548
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	06/13/2013
Patient Name	GONZALEZ
Doctor Name	BERENFELD
Due Date	08/11/2013
Tracking Number	796222345525

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0090	WS-1106ST .045" X 6" ST Guide Wire Batch: 291534	6 EA	15.00	90.00
0100	MS-DC28 2.8mm X 5" Quick Release Surgibit® Drill Batch: 299612	1 EA	75.00	75.00
			Total Amount USD	**2,503.00**

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Invoice
PAST DUE

Bill to

***SOUND SHORE HOSPITAL**
COD
16 GUION PLACE
NEW ROCHELLE NY 10802
VAT Reg:

Used at

SOUND SHORE HOSPITAL
ATTN: RECEIVING
16 GUION PLACE
NEW ROCHELLE NY 10802

Information

Invoice Number	90405062
Billing Date	07/30/2013
Sold to	103151
Customer PO	178129
Packing List Number	80636332
Sales Order Number	366303
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	06/27/2013
Patient Name	KELLY
Doctor Name	BERENFELD
Due Date	08/29/2013
Tracking Number	

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0010	PL-DR50L Acu-Loc® VDR Plate, Standard, Left	1 EA	949.00	949.00
0020	CO-3120 3.5mm X 12.0mm Cortical Screw	1 EA	77.00	77 00
0030	COL-3120 3.5mm x 12.0mm Locking Cortical Screw	1 EA	118.00	118.00
0040	COL-3140 3.5mm x 14.0mm Locking Cortical Screw	1 EA	118.00	118.00
0050	CO-T2316 2.3mm X 16mm Locking Cortical Screw	1 EA	104.00	104.00
0060	CO-T2318 2.3mm X 18mm Locking Cortical Screw	1 EA	104.00	104.00
0070	CO-T2320 2.3mm X 20mm Locking Cortical Screw	1 EA	104.00	104.00
0080	CO-T2322 2.3mm X 22mm Locking Cortical Screw	3 EA	104.00	312.00
0090	CO-S2318 2.3mm x 18mm Locking Cortical Peg	2 EA	104.00	208 00
0100	WS-1106ST .045" X 6" ST Guide Wire	6 EA	15.00	90.00
0110	MS-DC28 2.8mm X 5" Quick Release Surgibit® Drill	1 EA	75.00	75.00
			Total Amount USD	**2,259.00**

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Hillsboro, OR 97124
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Invoice
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VAT Reg:

Used at

SOUND SHORE HOSPITAL
ATTN: RECEIVING
16 GUION PLACE
NEW ROCHELLE NY 10802

Information

Invoice Number	90405063
Billing Date	07/30/2013
Sold to	103151
Customer PO	178130
Packing List Number	80644721
Sales Order Number	370892
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	07/23/2013
Patient Name	THOMPSON
Doctor Name	BARRENFELD
Due Date	08/29/2013
Tracking Number	

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0010	70-0304 Olecranon Plate, Standard 5-hole LT	1 EA	1,100.00	1,100.00
0020	30-0269 3.5mm x 36mm Non-Locking Hexalobe Screw	1 EA	91.00	91.00
0030	30-0263 3.5mm x 24mm Non-Locking Hexalobe Screw	1 EA	91.00	91.00
0040	30-0330 2.7mm x 20mm Locking Hexalobe Screw	2 EA	141.00	282.00
0050	30-0332 2.7mm x 24mm Locking Hexalobe Screw	1 EA	141.00	141 00
0060	30-0331 2.7mm x 22mm Locking Hexalobe Screw	1 EA	141.00	141.00
0070	30-0238 3.5mm x 20mm Locking Hexalobe Screw	1 EA	141.00	141.00
0080	30-0250 3.5mm x 50mm Locking Hexalobe Screw	1 EA	170.00	170.00
0090	30-0261 3.5mm x 20mm Non-Locking Hexalobe Screw	1 EA	91.00	91.00
0100	30-0239 3.5mm x 22mm Locking Hexalobe Screw	1 EA	141.00	141.00
0110	30-0267 3.5mm x 32mm Non-Locking Hexalobe Screw	1 EA	91.00	91 00

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PAST DUE

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ATTN: RECEIVING
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NEW ROCHELLE NY 10802

Information

Invoice Number	90405063
Billing Date	07/30/2013
Sold to	103151
Customer PO	178130
Packing List Number	80644721
Sales Order Number	370892
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	07/23/2013
Patient Name	THOMPSON
Doctor Name	BARRENFELD
Due Date	08/29/2013
Tracking Number	

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0120	WS-1406ST .054" X 6" Guide Wire	3 EA	15.00	45.00
0130	WS-1106ST .045" X 6" ST Guide Wire	1 EA	15.00	15.00
0140	80-0387 2.8mm Quick Release Surgibit® Drill	1 EA	121.00	121.00
0150	80-0318 2.0mm Quick Release Surgibit® Drill	1 EA	88.00	88.00
			Total Amount USD	**2,749.00**

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PHONE (503) 627-9957 EMAIL businessservices@acumed.net

Invoice
PAST DUE

Remit All Payments to
Acumed LLC
7995 Collection Center Drive
Chicago, IL 60693

Bill to

***SOUND SHORE HOSPITAL**
COD
16 GUION PLACE
NEW ROCHELLE NY 10802
VAT Reg:

Used at

SOUND SHORE HOSPITAL
ATTN: RECEIVING
16 GUION PLACE
NEW ROCHELLE NY 10802

Information

Invoice Number	90405064
Billing Date	07/30/2013
Sold to	103151
Customer PO	178131
Packing List Number	80645714
Sales Order Number	371690
Payment Terms	N030
Salesperson	Bioquest
Surgery Date	07/25/2013
Patient Name	SPANAL
Doctor Name	BERENFELD
Due Date	08/29/2013
Tracking Number	

Invoice Details

Item	Material Description	Quantity	Unit Price	Amount
0010	AT2-S32-S 32.0mm, Standard Acutrak 2® Bone Screw Batch: 259681	1 EA	523.00	523.00
0020	AT2-2515 Acutrak 2® Drill	1 EA	261.00	261.00
0030	WS-1407ST .054" X 7" ST Guide Wire	4 EA	15.00	60.00
			Total Amount USD	**844.00**

From: (503) 627-9957
SHIPPING DEPARTMENT
Acumed, LLC.
4860 NW Brookwood Pkwy

Hillsboro, OR 97124

Origin ID: VKWA

FedEx Express

J14101402070Suv

Ship Date: 14MAR14
ActWgt: 1.0 LB
CAD: 101887138/INET3490

Delivery Address Bar Code

Ref # GL654030 CC4000
Invoice #
PO #
Dept #

SHIP TO: (503) 627-9957 BILL SENDER

C/O GCG, INC
SOUND SHORE MEDICAL OF WESTCHESTER
PO BOX 9982

DUBLIN, OH 43017

TUE - 18 MAR AA
** 2DAY **

TRK# 7982 2567 7597
0201

43017
OH-US
LCK

SB OSUA

522G1/CC4F/F220

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)
TERESITA A. ALTAREJOS

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:
TERESITA A. ALTAREJOS
50 GUION PLACE APT 5E
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) SICK TIME 719.42 HRS BANK VACATION TIME 35.25 HRS

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN):

FILED - 01346
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 40,279.0012 (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: TERESITA A. ALTAREJOS
Title: RN
Company: SOUND SHORE MEDICAL CENTER OF WESTCHESTER
Address and telephone number (if different from notice address above):
Telephone number: (914) 636-2373

(Signature) _____ (Date) JAN 25, 2014

Company: _____
Address and telephone number (if different from notice address above)
email: _____
Telephone number: _____

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 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 1) Pg 10 of 44
Doc 1139-3
13-22840-rdd

OCTOBER 2013

				VACA N BANK				VACATION - 2013				BONUS				
				EFFECTIVE 12/31/97				MONTHLY	USAGE							
															15yrs+	
TITTLE	DATE OF HIRE	FTE		BEGINNING BALANCE	MONTH LYUSAGE	ENDING BALANCE		BEGINNING BALANCE	MONTHLYUSAGE	YEAR-TO-DATE	ENDING BALANCE	BEGINNING BALANCE	MONTHLYUSAGE	YTD	ENDING BALANCE	BEGINNING BALANCE
			NURSERY LEVEL.II													
			5160													
NC																
RN-2	01/04/1988	1.00	ALTAREJOS,T	35.25		35.25		37.50	37.50	150.00	0.00	0.00		7.50	0.00	736.92
RN-2	12/30/2002	1.00	BUNTING, N. (112.5 hrs vac prepaid	0.00		0.00		0.00		150.00	0.00					95.00
RN-2	05/13/2002	1.00	CRESPO, M	0.00		0.00		75.00	52.50	127.50	22.50					42.50
RN-2	12/01/1981	1.00	JACOB,A.M.	0.00		0.00		75.00	75.00	150.00	0.00	0.00		7.50	0.00	116.63
RN-2	02/09/2004	1.00	LAGARDE, DIANA	0.00		0.00		0.00		150.00	0.00					203.40
RN-2	06/17/1996	1.00	LIVERZANI, S	0.00		0.00		47.50	35.00	137.50	12.50	0.00		7.50	0.00	67.50
RN-2	04/06/1998	1.00	PAGNOTTA, M TRN. NICU 7/28/13	0.00		0.00		12.50	12.50	150.00	0.00	7.50	5.00	5.00	2.50	57.50
RN-2	12/20/2009	1.00	PEREZ, M	0.00		0.00		62.25	62.25	150.00	0.00					73.50
RN-2	01/29/1996	1.00	SIKORJAK,HELEN	0.00		0.00		75.00	74.50	149.50	0.50	0.00		7.50	0.00	247.50
RN	04/19/2004	1.00	STEPHEN, Mini LOA 9/21/13-10/11/13	0.00		0.00		0.00		150.00	0.00					72.26
RN	12/30/2002	0.34	STEINBERG-RIZZUTO, S.(.34)	0.00		0.00		0.00		52.00	0.00					0.00

Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Doc 1139-3 (Part 1) Pg 11 of 44
13-28411-rdd

OCTOBER 2013

	SICK				HOLIDAY MONTHLY				FREE MONTHLY			
	MONTHLY ACCRUED	MONTHLY USAGE	YEAR-TO-DATE	ENDING BALANCE	BEGINNING BALANCE	MONTHLYUSAGE	YEAR-TO-DATE	ENDING BALANCE	BEGINNING BALANCE	MONTHLY USAGE	YEAR-TO-DATE	ENDING BALANCE
	=	=		=						=		
NURSERY LEVEL II												
160												
ALTAREJOS,T	7.50	**25.00**	25.00	**719.42**	5.00	**5.00**	60.00	**0.00**	0.00		30.00	**0.00**
UNTING, N. (112.5 hrs vac prepaid	7.50		0.00	**102.50**	0.00		60.00	**0.00**	0.00		30.00	**0.00**
RESPO, M	7.50	**25.00**	25.00	**25.00**	10.00	**10.00**	60.00	**0.00**	0.00		30.00	**0.00**
ACOB,A.M.	7.50	**12.50**	12.50	**111.63**	17.50	**15.25**	57.75	**2.25**	5.00		25.00	**5.00**
AGARDE, DIANA	7.50		0.00	**210.90**	0.00		60.00	**0.00**	2.50	**1.50**	29.00	**1.00**
IVERZANI, S	7.50	**12.50**	12.50	**62.50**	0.00		60.00	**0.00**	0.00		30.00	**0.00**
AGNOTTA, M TRN. NICU 7/28/13	7.50		0.00	**65.00**	0.00		60.00	**0.00**	2.50		27.50	**2.50**
EREZ, M	7.50	**25.00**	25.00	**56.00**	0.00		60.00	**0.00**	0.00		30.00	**0.00**
IKORJAK,HELEN	7.50		0.00	**255.00**	17.50	**5.00**	47.50	**12.50**	14.00	**14.00**	30.00	**0.00**
TEPHEN, Mini LOA 9/21/13-10/11/13	7.50	**44.48**	44.48	**35.28**	0.00		60.00	**0.00**	2.50		27.50	**2.50**
TEINBERG-RIZZUTO, S.(.34)	2.60		0.00	**2.60**	0.00		21.00	**0.00**	0.00		10.00	**0.00**

13-22840-rdd Doc 1139-3 Filed 06/29/15 Entered 06/29/15 15:01:16 Exhibits (Part 1) Pg 12 of 44

TERESITA A. ALTAREJ
50 GUION PLACE APT
NEW ROCHELLE NY
10801

7013 1710 0000 5127 3989

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL™

7013 1710 0000 5127 3989

UNITED STATES POSTAL SERVICE

1000

43017

U.S. POSTAGE
PAID
NEW ROCHELLE.NY
10801
JAN 25.'14
AMOUNT

$6.77

00053453-16

SOUND SHORE MEDICAL OF WESTCHESTER, ET AL.,
C/O GCG, INC. P.O. BOX 9982
DUBLIN, OHIO
43017-5982

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)
Atlas Party Rentals

☐ 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. MAR - 4 2014

Name and Addresses Where Notices Should be Sent:
554 South Columbus Ave
Mount Vernon, NY. 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): 9/11 & 10/2

3. DESCRIPTION OF CLAIM (IF KNOWN): 3 Rentals

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1639.00 (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: Gary Shure
Title: Vp
Company: Atlas Party Rentals
Address and telephone number (if different from notice address above):
554 South Columbus Ave
Mt. Vernon NY 10550
Telephone number: 914-636-6431

(Signature) _____ (Date) 2/20/14

email: GARY@AtlasPartyrentals.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 - 01471
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

PROMPT PROFESSIONAL SERVICE

ATLAS PARTY RENTALS
AAA/BEST CHAIR RENTALS
554 South Columbus Avenue
Mount Vernon, NY 10550

Fax (914) 699-9778
(212) 929-8888 • (914) 636-6431

INVOICE

DATE	INVOICE NO.
9/10/2013	$0122

BILL TO:

Sound Shore Medical Center in Possession
16 Guion Place
New Rochelle, NY 10801
Accts Payable
pdavis@nmsc.com

Phil

SHIP TO:

Sound Shore Medical Center
16 Guion Place Del to cafeteria
Cecelia May 914-365-3581
Anum 384-1823 Paul 365-1426
Sandra 914-365-3065/Jasmine

bob
cmte

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
	7 DAYS	GS	9/11/2013	Our Truck	09/12/13	

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
24	BQ	WHITE Table Cloth - 72 x 120	11.50	276.00
1	SK14	POPPY Table Skirts - 14' Long	28.00	28.00
45	NAP	POPPY Napkins	1.00	45.00
4	CH	Chafing Dishes / With Sterno Cans	16.00	64.00
10	GWP	Glass Water Pitcher	5.00	50.00
4	DN	Doz. Dinner Plate	7.00	28.00
-	SN	Doz. Small Plate	7.00	0.00
7	B&B	Doz. Bread & Butter Plate	7.00	49.00
3	CS	Doz. Cup & Saucer	12.00	36.00
1	FLAT	Doz. Fork, Knife, Teaspoon, Dess. Fork	18.00	72.00
4	BALW	Doz. Balloon Wine	10.00	40.00
1	HB	Doz. Highball Glasses	9.00	36.00
4	AP	Doz. All Purpose Wine	8.00	32.00
	TAPE		1.00	0.00

To avoid additional charges all tables and chairs must be folded, stacked and bagged for pick-up.
You are responsible for missing or damaged merchandise and agree to pay for same.
All deliveries and pickups are to ground floor or elevator buildings only. Any flights of stairs are subject to additional charges of up to $200 per occurence.
Customer assumes all costs and risks associated with weather conditions and other acts of God.
For more info, visit www.partyrenter.com and select 'our policies'.
PRINT NAME _____
Customer has received all items listed above. If any merchandise is missing or damaged customer agrees to notify Atlas/AAA Best Chair Rentals within 12 hours of delivery.
XX _____

122

TOTAL $805.00

Atlas Party Rentals
AAA/Best Chair Rentals

GARY SHURE

554 South Columbus Avenue
Mount Vernon, NY 10550

PH - 212-929-8888
914-636-6431
FAX - 914-699-9778

gary@atlaspartyrentals.com
www.partyrenter.com

INVOICE

PROMPT PROFESSIONAL SERVICE

ATLAS PARTY RENTALS
AAA/BEST CHAIR RENTALS
554 South Columbus Avenue
Mount Vernon, NY 10550

Fax (914) 699-9778
(212) 929-8888 • (914) 636-6431

DATE	INVOICE NO
10/1/2013	80454

BILL TO:

Sound Shore Medical Debtor in Possession
16 Guion Place
New Rochelle, NY 10801
Accts Payable
pdavis@nmsc.com

SHIP TO:

Sound Shore Medical Center
16 Guion Place del to cafeteria
Cecelia Moy 914-265-3581
Arum 384-1323 Paul 365-4026
Sandra 914-365-3065/Jasmine

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
5 pm	7 DAYS	GS	10/2/2013	Our Truck	10/03/13	

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
20	BQ	White Table Cloth - 72 x 120	11.50	230.0
1	SK14	White Table Skirts - 14' Long	28.00	28.0
40	NAP	Gold Napkins	1.00	40.0
4	DN	Doz. Dinner Plate	7.00	28.0
7	SM	Doz. Small Plate	7.00	49.0
7	B&B	Doz. Bread & Butter Plate	7.00	49.0
3	CS	Doz. Cup & Saucer	12.00	36.0
4	FL	Doz. Fluted Champagne Glass	18.00	72.0
4	BALW	Doz. Balloon Wine	10.00	40.0
4	HB	Doz. Hiball Glasses	9.00	36.0
4	AP	Doz. All Purpose Wine	8.00	32.0
10	GWP	Glass Water Pitcher	5.00	50.0
4	CH	Chafing Dishes / With Sterno Cans	16.00	64.0
	NOTE	To avoid additional charges all tables and chairs must be folded, stacked and bagged for pick-up.	0.00	0.0
		You are responsible for missing or damaged merchandise and agree to pay for same.		
		All deliveries and pickups are to ground floor or elevator buildings only. Any flights of stairs are subject to additional charges of up to $200 per occurence		
		Customer assumes all costs and risks associated with weather conditions and other acts of God		
		For more info,visit www.partyrenter.com and select 'our policies'.		
		PRINT NAME _____		
		Customer has received all items listed above. If any merchandise is missing or damaged customer agrees to notify Atlas/AAA Best Chair Rentals within 12 hours of delivery.		
		XX Tom O'Wilson		
			TOTAL	$754.0

INVOICE

PROMPT & PROFESSIONAL SERVICE

ATLAS PARTY RENTALS
AAA/BEST CHAIR RENTALS
554 South Columbus Avenue
Mount Vernon, NY 10550

Fax (914) 699-9778
(212) 929-8888 • (914) 636-6431

DATE	INVOICE NO
10/2/2013	80481

BILL TO:

Sound Shore Medical Debtor in Possession
16 Guion Place
New Rochelle, NY 10801
Accts Payable
pdavis@nmsc.com

SHIP TO:

Sound Shore Medical Center
16 Guion Place del to cafeteria
Cecelia Moy 914-265-3581
Arum 384-1323 Paul 365-4026
Sandra 914-365-3065/Jasmine

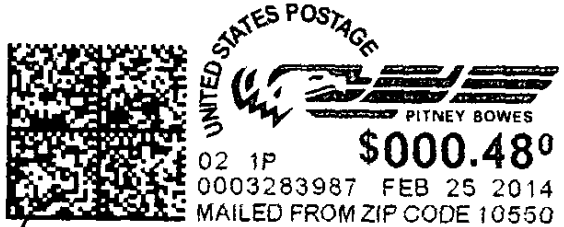
Sound Shore Sade

P.O. NUMBER	TERMS	REP	SHIP	VIA	F.O.B.	PROJECT
	7 DAYS	GS	10/2/2013	Our Truck	10/03/13	

QUANTITY	ITEM CODE	DESCRIPTION	PRICE EACH	AMOUNT
4	FLAT	Doz. Fork, Knife, Teaspoon, Dess. Fork	20.00	80.0
	WEB	Your signiture on this invoice indicates acceptance of all terms and conditions stated on our website. You can view them at www.partyrenter.com	0.00	0.0
			TOTAL	$80.00

13-22840-rdd Doc 1139-3 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 1) Pg 18 of 44

ATLAS PARTY RENTALS
AAA/BEST CHAIR RENTALS
554 South Columbus Avenue
Mount Vernon, NY 10550



Sound SHORE MEDICAL
OF Westchester

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)
Berchtold Corporation.

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:
Berchtold Corporation
1950 Hanahan Road
Charleston, S.C. 29406

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:
6800003320

FILED - 01352
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YOR

SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

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): 10/03/2013

3. DESCRIPTION OF CLAIM (IF KNOWN):
Service / Parts used - Repair to Surgical Equipment.

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1,349.50 (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: Steven M. Roberts
Title: Accounts Receivable Specialist
Company: Berchtold Corporation

Steven M. Roberts (Signature) 1/27/2014 (Date)

Address and telephone number (if different from notice address above):

Telephone number: 843-569-6166 email: steve.roberts@Berchtold.biz

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.

BERCHTOLD®

1950 Hanahan Road
Charleston, SC 29406
800-243-5135 * 843-569-6100 Fax: 843-569-6133
www.berchtoldusa.com

Bill-to address
SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE NY 10802

Ship-to address
SOUND SHORE MEDICAL CENTER
ACCOUNTS PAYABLE DEPARTMENT
16 GUION PLACE
NEW ROCHELLE NY 10802

Invoice

Document no./Date	69120231	/ 10/03/2013
Reference Number	NR177786	
Date	07/12/2013	
Delivery Note/Date	68123024	/ 10/03/2013
Order no./Date	63001259	/ 10/03/2013
Customer no.	6800003320	
Contact person	TSMITH	

Service Tech DReynolds Date of Service 7/12/13
SF Cases 101832 & 101833
OR5 Light handles are burned and arched. Replaced B'ring, A'ring, connector rod and replaced contact. Light checks good.
OR6 Light handles are burned and arched. Replaced B'ring, A'ring, connector rod and replaced contact. Light checks good.

Conditions:

Terms of payment	Up to 11/02/2013 without deduction
Terms of delivery	EXW CHARLESTON, PREPAID&ADD

Currency USD

Pos.	Item no.	Description	Qty
1	64778		2 PCE
		Guide Stick	
		Guide Stick	
		Type **Amount**	**Value**
		Unit Price 39.35 USD	78.70
2	62406		2 PCE
		Ring "B" black	
		Ring "B" black	
		Type **Amount**	**Value**
		Unit Price 26.47 USD	52.94
3	62405		2 PCE
		Ring "A" black	
		Ring "A" black	
		Type **Amount**	**Value**
		Unit Price 24.93 USD	49.86

BERCHTOLD®

1950 Hanahan Road
Charleston, SC 29406
800-243-5135 * 843-569-6100 Fax: 843-569-6133
www.berchtoldusa.com

SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE NY 10802

Document no./Date
69120231 / 10/03/2013

Pos.	Item no.	Description	Qty	
4	**RS 0006015**		2 PCE	
		78851 Contact Spring Block		
		Miscellaneous		
		Type / **Amount**		**Value**
		Unit Price 106.00 USD		212.00
5	**RS 0006014**		16 PCE	
		Labor - 1/4 hour increment		
		Labor ¼ Hour Increment		
		Type / **Amount**		**Value**
		Unit Price 44.00 USD		704.00
6	**RS 0006013**		8 PCE	
		Travel - 1/4 hour increment		
		Travel ¼ Hour Increment		
		Type / **Amount**		**Value**
		Unit Price 31.50 USD		252.00
Items total:				1,349.50
Total amount:				**1,349.50**

BERCHTOLD

Steve Roberts
Accounting Specialist

1950 Hanahan Road
Charleston, SC 29406

Phone 843-569-6100 ext. 258
800-243-5135
Fax 843-569-6133

Steve.Roberts@BERCHTOLD.biz

13-22840-rdd Doc 1139-3 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 1) Pg 22 of 44

BERCHTOLD

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.48⁰
0003093697 JAN 31 2014
MAILED FROM ZIP CODE 29406

Sound Shore Medical of Westchester
C/O GCG, Inc.
P.O. Box 9982
Dublin, OH 43017-5982

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)

☐ 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. APR 16 2014

Name and Addresses Where Notices Should be Sent.

Stephen Bowen
37 Rochelle Place
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
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a)
☑ Wages (Dates) Wages / 1199 ☐ Other (Specify): Grandfathered PTO

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ $25,000 (Total) Wages - PTO - Grandfathered Vacation Time

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: STEPHEN BOWEN Stephen Bowen
Title: _____ (Signature) (Date)
Company. _____
Address and telephone number (if different from notice address above):

FILED - 01484
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Telephone number: _____ 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.

13-22840-rdd Doc 1139-3 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Exhibit A Part 1 Pg 24 of 44

Stephen Bowen
32 Rochelle Place
New Rochelle NY 10801

11 APR 2014 PM 4 L

USA • FOREVER

Sound Shore Meical of Westchester
P.O Box 9982
Dublin Ohio 43017-5982

43017598282

FILED - 01486
U.S. BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER, ET AL.
ROBERT D. DRAIN

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)

☐ 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. APR 29 2014

Name and Addresses Where Notices Should be Sent:

Calabria Society
81 Union Ave
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) Annual Dinner

2. DATE DEBT WAS INCURRED (IF KNOWN): November 2012

3. DESCRIPTION OF CLAIM (IF KNOWN):
Purchased status of 10 for Annual Dinner Dance 10 x $110 pp = $1100

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM $ 1100 (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: Pasquale Procopio
Title: Trustee
Company: Calabria Society
Address and telephone number (if different from notice address above):
81 Union Ave
New Rochelle NY 10801
Telephone number 914-588-0116

(Signature) _____ (Date) 4-21-14

email: pdpcp@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.

13-22840-rdd Doc 1139-3 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
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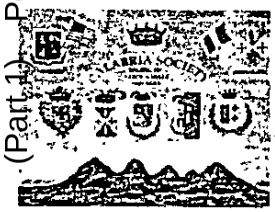
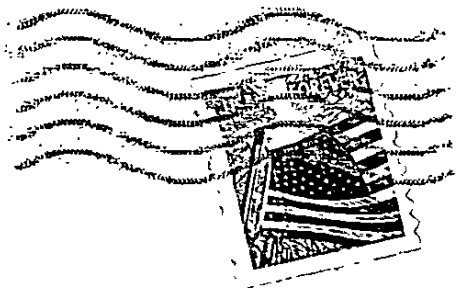


Calabria Society
81 Union Avenue
New Rochelle, NY 10801



Sound Shore Medical of West. 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

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

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☐ 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 CONKLIN

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:
BARBARA CONKLIN
59 EMERSON AVE
NEW ROCHELLE N.Y.

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:

FILED - 01351
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YOI
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

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): BANK VACATION + 1 WEEK CURRENT VACATION

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

3. DESCRIPTION OF CLAIM (IF KNOWN): LOSSED VACATION WAGES

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 12½ WEEKS BANK VACATION (Total) 1 WEEK VACATION 2013

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.

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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 CONKLIN
Title: REGISTERED NURSE
Company: _____
Address and telephone number (if different from notice address above):

Barbara Conklin (Signature) 12/24/13 (Date)

Telephone number: _____ email: BCCELICA@AOL

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

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13-22840-rdd

for Barbara Conklin

OCTOBER 2013 PPE 10/5/13

TITLE	DATE OF HIRE	FTE	PR3	VACATION BANK EFFECTIVE 12/31/97 BEGINNING BALANCE	VACATION BANK EFFECTIVE 12/31/97 MONTHLY USAGE	VACATION BANK EFFECTIVE 12/31/97 ENDING BALANCE	VAC 2013 BEGINNING BALANCE	VAC 2013 MONTHLY USAGE	VAC 2013 YEAR-TO-DATE	VAC 2013 ENDING BALANCE	BONUS 7/1/2005 BEGINNING BALANCE	BONUS 7/1/2005 MONTHLY USAGE	BONUS 7/1/2005 YEAR-TO-DATE	15yrs + ENDING BALANCE	BEGINNING BALANCE
			GI CENTER												
			5195												
RN-2	06/10/2002	1.00	[redacted]	0.00		**0.00**	47.50	2.50	105.00	**45.00**					822.50
ANCC	06/13/1977	1.00	CONKLIN B (LOA 3/27 - 4/18/12)	499.00		**499.00**	29.25		120.75	**29.25**	0.00		7.50	**0.00**	727.88
CHIEF	05/01/1991	1.00	[redacted]	187.75		**187.75**	6.25		143.75	**6.25**					900.00
RN	12/10/2001	1.00	[redacted]	0.00		**0.00**	51.00		99.00	**51.00**					342.50
OST TECH	09/01/1985	1.00	[redacted]	38.93		**38.93**	28.00		122.00	**28.00**					124.60
RN	10/15/2008	1.00	[redacted]	0.00		**0.00**	29.00	7.50	128.50	**21.50**					275.02
RN (22.5)	5/11/2009	0.60	[redacted] resigned 10/30/13	0.00		**0.00**	32.00	0.50	58.50	**31.50**					289.00
RN-2	01/21/1978	1.00	[redacted]	420.56		**420.56**	0.00		150.00	**0.00**	0.00		7.50	**0.00**	900.00
RN (15.00)	07/01/1979	0.40	[redacted]	162.80		**162.80**	11.50	7.50	56.00	**4.00**	3.00		0.00	**3.00**	335.05
RN	12/01/1985	1.00	[redacted]	0.00		**0.00**	16.50		133.50	**16.50**	7.50		0.00	**7.50**	263.64
TECHNICIAN	01/08/2002	1.00	[redacted]	0.00		**0.00**	52.50		97.50	**52.50**					354.50
RN	02/07/2005	1.00	[redacted]	0.00		**0.00**	22.50	7.50	135.00	**15.00**					446.70

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OCTOBER 2013		SICK				HOLIDAY				FREE		
PR3	MONTHY ACCRUED	MONTHLY USAGE	YEAR-TO-DATE	ENDING BALANCE	BEGINNING BALANCE	MONTHLY USAGE	YEAR-TO-DATE	ENDING BALANCE	BEGINNING BALANCE	MONTHLY USAGE	YEAR-TO-DATE	ENDING BALANCE
CENTER												
295												
[redacted]	7.50		0.00	**830.00**	15.00		45.00	**15.00**	0.00		30.00	**0.00**
CONKLIN,B (LOA 3/27-4/18/12)	7.50		0.00	**727.88**	15.00		45.00	**15.00**	7.50		22.50	**7.50**
[redacted]	0.00		0.00	**900.00**	15.00		45.00	**15.00**	7.50		22.50	**7.50**
[redacted]	7.50		0.00	**350.00**	15.00		45.00	**15.00**	0.00		30.00	**0.00**
[redacted]	7.50		0.00	**132.10**	15.00		45.00	**15.00**	0.00		30.00	**0.00**
[redacted]	7.50		0.00	**282.52**	15.00		45.00	**15.00**	0.00		30.00	**0.00**
[redacted] signed 10/30/13	4.50		0.00	**293.50**	13.50		22.50	**13.50**	0.00		18.00	**0.00**
[redacted]	0.00		0.00	**900.00**	14.50		45.50	**14.50**	0.00		30.00	**0.00**
[redacted]	3.00		0.00	**338.05**	9.00		15.00	**9.00**	0.00		12.00	**0.00**
[redacted]	7.50		0.00	**271.14**	15.00		45.00	**15.00**	0.00		30.00	**0.00**
[redacted]	7.50		0.00	**362.00**	15.00		45.00	**15.00**	13.00		17.00	**13.00**
[redacted]	7.50		0.00	**454.20**	15.00		45.00	**15.00**	7.50		22.50	**7.50**

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(Part 1) Pg 30 of 44

Barbara Conklin
89 Emerson Ave.
New Rochelle, NY 10801-5309

WESTCHESTER NY 105
29 JAN 2014 PM 5 L

FOREVER

Sound Shore Medical of Westchester
c/o GCG Inc.
PO 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.
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☐ 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)
Gerard Corbett

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent.
Gerard Corbett
P.O. Box 608
Bronx, NY 10465

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:
SSN: 053-50-8404

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): 12/28/12, 01/08/13 + 03/08/13

3. DESCRIPTION OF CLAIM (IF KNOWN). Services performed - Musical Entertainment

FILED - 01349
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 300.00 (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: Gerard Corbett
Title: Independant Contractor
Company: N/A
Address and telephone number (if different from notice address above):

Gerard Corbett (Signature) 01/27/14 (Date)

Telephone number: (631)235-0803 email: gerardcorbett3@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

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Gerard Corbett
P.O. Box 608
Bronx, NY 10465
(631) 235-0803
Gerardcorbett3@gmail.com

January 27, 2014

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

RE: Administrative Expense Proof of Claim

To Whom It May Concern:

Enclosed please find **Administrative Expense Proof of Claim** form for services rendered on December 28, 2012, January 8, 2013 and March 8, 2013.

Also enclosed are three (3) invoices for the above said performances. Please note that I have already submitted these forms. Hopefully, this will suffice in order that I may receive compensation for above said performances.

If you have any questions or require additional information, please contact me via the above correspondences. Thanking you in advance for your attention to the above.

Sincerely,

Gerard Corbett

Gerard Corbett

Enc.

INVOICE

Gerard Corbett
P.O. Box 608
Bronx, NY 10465
(631) 235-0803
E-Mail: gerardcorbett3@gmail.com

PLEASE MAIL CHECK(S) TO P.O. BOX ABOVE.

To: **Helen & Michael Schaffer ECC**

16 Guion Place

New Rochelle, NY 10801

(914) 365-3838

ATT: **Susan Mouris, Recreation Department**

Event: **"Entertainment"**

Date of Event: **December 28, 2012**

Time: **2:30 - 3:30 PM**

Fee: **$100.00**

****Please make check payable to: Gerard Corbett**

TIN: XX-XXX-8404

THANK YOU FOR YOUR BUSINESS!

BOOKINGS STILL AVAILABLE FOR 2012

NOW BOOKING FOR 2013

Gerard Corbett

Gerard Corbett

INVOICE

Gerard Corbett
P.O. Box 608
Bronx, NY 10465
(631) 235-0803
E-Mail: gerardcorbett3@gmail.com

PLEASE MAIL CHECK(S) TO P.O. BOX ABOVE.

To: Helen & Michael Schaffer ECC

16 Guion Place

New Rochelle, NY 10801

(914) 365-3838

ATT: Susan Mouris, Recreation Department

Event: "Entertainment - Elvis Show"

Date of Event: January 8, 2012

Time: 2:30 - 3:30 PM

Fee: $100.00

****Please make check payable to: Gerard Corbett**

TIN: XX-XXX-8404

THANK YOU FOR YOUR BUSINESS!

BOOKINGS STILL AVAILABLE FOR 2013

Gerard Corbett
Gerard Corbett

INVOICE

Gerard Corbett
P.O. Box 608
Bronx, NY 10465
(631) 235-0803
E-Mail: gerardcorbett3@gmail.com

PLEASE MAIL CHECK(S) TO P.O. BOX ABOVE.

To: Helen & Michael Schaffer ECC

16 Guion Place

New Rochelle, NY 10801

(914) 365-3838

ATT: Susan Mouris, Recreation Department

Event: "Entertainment"

Date of Event: March 8, 2013

Time: 2:30 - 3:30 PM

Fee: $100.00

****Please make check payable to: Gerard Corbett**

TIN: XX-XXX-8404

THANK YOU FOR YOUR BUSINESS!

BOOKINGS STILL AVAILABLE FOR 2013

Gerard Corbett
Gerard Corbett

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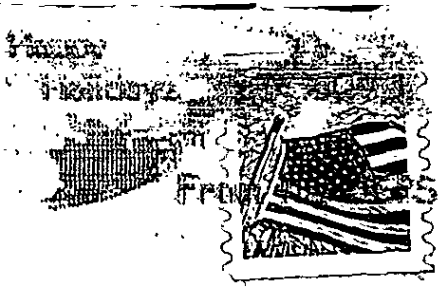
(Part 1) Pg 36 of 44

Gerard Corbett
P.O. Box 608
Bronx, NY 10465

NEW YORK NY 100

30 JAN 2015 PM 11 L



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

SOUTHERN DISTRICT OF NEW YORK

PROOF OF CLAIM

Administrative Expense Bar Date: January 31, 2014

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☐ 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)
Herbert Cornell

☐ 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:
Herbert Cornell
67 So. 7th Ave
Mt. Vernon, N.Y. 10550

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

Claim Number (if known): _____

Dated: _____

2014 MAR 28 A 10:16 FILED U.S. BANKRUPTCY COURT S.D. OF N.Y.

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR:

1. BASIS FOR CLAIM:
☐ Goods sold ☐ Services performed ☐ Personal Injury/Wrongful Death ☑ Wages (Dates) 7/04 - 11/13
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☐ Other (Specify): _____

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

3. DESCRIPTION OF CLAIM (IF KNOWN): Unpaid WAGES

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 4,000 (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: Herbert Cornell
Title: CASE MANAGER
Company: Mt. Vernon Hospital
Address and telephone number (if different from notice address above):

Herbert Cornell (Signature) 1/20/14 (Date)

Telephone number: 914 620-7182 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.

CRT

2014 MAR 28 A 10:16 FILED U.S. BANKRUPTCY COURT S.D. OF N.Y.

THE GARDEN CITY GROUP, INC. JUN 18 2014

FILED - 01500
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

October 24, 2013

BY FIRST-CLASS MAIL

FILED
U.S. BANKRUPTCY COURT
2014 MAR 28 A 10:16
S.D. OF N.Y.

Cornell,Herbert
677 So. 7th Ave,
Mt Vernon, NY
10550

Re: **Sound Shore Health System Bankruptcy**

Dear Member:

As you know, both Sound Shore Medical Center and the Mount Vernon Hospital filed for bankruptcy at the end of May. In August, the Bankruptcy Court approved a sale of Sound Shore and Mount Vernon to Montefiore Medical Center. This sale is expected to close on October 31, 2013.

1199 is working hard to ensure that members who are hired by Montefiore as part of the sale are able to keep as much of their accrued time off as possible. As part of this process, we need to confirm how much time everyone has accrued. Attached to this letter is a statement from Sound Shore or Mount Vernon specifying the amounts that you accrued according to the hospitals' records. Please carefully review this statement.

If you disagree with any of the amounts listed in the attached statement from Sound Shore/Mount Vernon, you must contact your organizer, in writing, no later than Tuesday, October 30, 2013 and provide information proving that the amounts are incorrect. Contact information for your organizer is below. **If you fail to contact your organizer by Tuesday, October 30, 2013, your accruals will be those listed on the attached statement.**

If you do not disagree with the vacation, personal, holiday, sick, or grandfathered time accruals listed in the attached statement, you need not do anything. The Union and its attorneys will meet with Sound Shore and Mount Vernon to resolve any disputes.

Cornell,Herbert accrued but unused paid-time-off, as of October 5, 2013, according to Mount Vernon Hospital's records:

Vacation Time: 52.5 hours

Free Time: 11.25 hours

Holiday Time: 7.5 hours

Sick Time: 302.5 hours

Grandfathered Time (if applicable): 0 hours

#19.75

If necessary, you may contact your organizer at:

Sound Shore	Mount Vernon
Vincent Waters	Brenda Spry
99 Church Street, Floor 4	99 Church Street, Floor 4
White Plains, NY 10601-1528	White Plains, NY 10601-1528
914-815-8923 (cell)	914-346-7185 (cell)
914-993-6714 (fax)	914-993-6714 (fax)
vincent.waters@1199.org	brenda.spry@1199.org

Sincerely,

Lisa Brown

LB:str

Sound Shore Health System

Sound Shore Medical Center • Mount Vernon Hospital • Schaffer Extended Care Center • Hopfer School of Nursing

To: All SSHS Employees
Date: October 31, 2013
RE: *EXTENSION of Notice, pursuant to the Worker Adjustment and Retraining Notification Act ("WARN") – Sound Shore Health System, Inc., Sound Shore Medical Center of Westchester, The Mount Vernon Hospital, Howe Avenue Nursing Home d.b.a. Helen and Michael Schaffer Extended Care Center, NRHMC Services Corporation, The M.V.H. Corporation and New Rochelle Sound Shore Housing LLC (collectively called the "Companies")*

This notice is to inform you that the original Date Range of the expected discontinuance of operations of the Companies has been extended. The Companies now intend permanently to discontinue their operations, effective between November 1, 2013 and November 15, 2013 (the "Extended "Date Range").

On July 22nd, 2013 The Companies sent out the necessary notices under the WARN law to all of the employees of the companies listed above, as well as to the unions representing employees within the companies above, as well as to the various government representatives who are also required to receive notice under the WARN law. You received a copy of that WARN notice. You should refer to that original WARN notice for the full details of the notice.

The reason for this extension of the effective date of the discontinuance of operations is that the preparations for the discontinuance of the Companies' operations and the closing and sale of the Companies to the Montefiore Health System have not yet been fully finalized. The parties are still working to satisfy the conditions of closing of the sale

This notice of the "Extended Date Range" is being given to you pursuant to the New York State and Federal Worker Adjustment and Retraining Notification Acts. ("WARN")

Should you have any questions, please contact Dennis Ashley at 914-365-4802.

Sincerely,

Dennis Ashley
Senior Vice President, Human Resources

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: June 17, 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: 6

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

Herbert Cornell	$4,000.00
Lexis Nexis	$3,873.62
Empire Healthchoice Assurance	(See Attachment)
Empire Healthchoice Assurance	(See Attachment)
State of NY Dept of Labor	$129,008.79
State of NY Dept of Labor	$310,798.20

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: _____

If Borrower is not a natural Person and a beneficial interest in Borrower is sold or transferred without Lender's prior written permission, Lender also may require Immediate Payment in Full. However, this option shall not be exercised by Lender if such exercise is prohibited by Applicable Law.

If Lender requires Immediate Payment in Full under this Section 18, Lender will give me a notice which states this requirement. The notice will give me at least 30 days to make the required payment. The 30-day period will begin on the date the notice is given to me in the manner required by Section 15 of this Security Instrument. If I do not make the required payment during that period, Lender may act to enforce its rights under this Security Instrument without giving me any further notice or demand for payment.

19. Borrower's Right to Have Lender's Enforcement of this Security Instrument Discontinued. Even if Lender has required Immediate Payment in Full, I may have the right to have enforcement of this Security Instrument stopped. I will have this right at any time before the earliest of: (a) five days before sale of the Property under any power of sale granted by this Security Instrument; (b) another period as Applicable Law might specify for the termination of my right to have enforcement of the Loan stopped; or (c) a judgment has been entered enforcing this Security Instrument. In order to have this right, I will meet the following conditions:

(a) I pay to Lender the full amount that then would be due under this Security Instrument and the Note as if Immediate Payment in Full had never been required;

(b) I correct my failure to keep any of my other promises or agreements made in this Security Instrument;

(c) I pay all of Lender's reasonable expenses in enforcing this Security Instrument including, for example, reasonable attorneys' fees, property inspection and valuation fees, and other fees incurred for the purpose of protecting Lender's interest in the Property and rights under this Security Instrument; and

(d) I do whatever Lender reasonably requires to assure that Lender's interest in the Property and rights under this Security Instrument and my obligations under the Note and under this Security Instrument continue unchanged.

Lender may require that I pay the sums and expenses mentioned in (a) through (d) in one or more of the following forms, as selected by Lender: (a) cash; (b) money order; (c) certified check, bank check, treasurer's check or cashier's check drawn upon an institution whose deposits are insured by a federal agency, instrumentality or entity; or (d) Electronic Funds Transfer.

If I fulfill all of the conditions in this Section 19, then this Security Instrument will remain in full effect as if Immediate Payment in Full had never been required. However, I will not have the right to have Lender's enforcement of this Security Instrument discontinued if Lender has required Immediate Payment in Full under Section 18 of this Security Instrument.

20. Note Holder's Right to Sell the Note or an Interest in the Note; Borrower's Right to Notice of Change of Loan Servicer; Lender's and Borrower's Right to Notice of Grievance. The Note, or an interest in the Note, together with this Security Instrument, may be sold one or more times. I might not receive any prior notice of these sales.

The entity that collects the Periodic Payments and performs other mortgage loan servicing obligations under the Note, this Security Instrument, and Applicable Law is called the "Loan Servicer." There may be a change of the Loan Servicer as a result of the sale of the Note. There also may be one or more changes of the Loan Servicer unrelated to a sale of the Note. Applicable Law requires that I be given written notice of any change of the Loan Servicer. The notice will state the name and address of the new Loan Servicer, and also tell me the address to which I should make my payments. The notice also will contain any other information required by RESPA or Applicable Law. If the Note is sold and thereafter the Loan is serviced by a Loan Servicer other than the purchaser of the Note, the mortgage loan servicing obligations to me will remain with the Loan Servicer or be transferred to a successor Loan Servicer and are not assumed by the Note purchaser unless otherwise provided by the Note purchaser.

Neither I nor Lender may commence, join or be joined to any court action (as either an individual party or the member of a class) that arises from the other party's actions pursuant to this Security Instrument or that alleges that the other has not fulfilled any of its obligations under this Security Instrument, unless the other is notified (in the manner required under Section 15 of this Security Instrument) of the unfulfilled obligation and given a reasonable time period to take corrective action. If Applicable Law provides a time period which

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

J1311302120326

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 6578
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.

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 $500, 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)
Roger Coron

☐ 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. MAY 27 2014

Name and Addresses Where Notices Should be Sent:
37 Carrington Drive
Greenwich CT 06831

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) Tail Insurance

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN):
Tail Insurance

FILED - 01493
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 24,989 (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: Roger Coron
Title: MD - Physician
Company: Sound Shore Medical Center

(Signature) 5/12/14 (Date)

Address and telephone number (if different from notice address above):

Telephone number: 973 632-7323 email: ROGER.CORON@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.

To Sound Shore Medical Center of Westchester, et, al.,

c/o GCG

PO BOX 9982

Dublin, OH 43017-9982

Please see the enclosed documents. I was a full time employed physician at Sound Shore Medical Center. As part of my compensation, malpractice insurance was provided for me in full by the hospital. Due to the bankruptcy I have been left to pay for Tail insurance in the amount of $24,989. I am paying this in 3 parts. I submitted the first payment of 8,330.00 on May 1st 2014. I owe 8330 on 1/1/15 and 8329 on 1/1/16. I will also own an additional 11% interest on this policy.

Since my contract was rejected at the bankruptcy proceedings Sound Shore owes me 24,989.

If you need more information please do not hesitate to contact me. I understand the Administrative expense bar date has been postponed to July 7, 2014

Thank you,

Roger Coron

37 Carrington Drive

Greenwich, CT 06831

Physicians' Reciprocal Insurers
1800 Northern Boulevard, P. O. Box 9007, Roslyn, New York 11576
(516) 365-6690
(800) 632-6040
www.pri.com

I discussed c Joe. He said I have to send first installment before they send me bank notes.

TAIL COVERAGE PREMIUM NOTICE

He/she said that if the policy ends Nov 6, 2013 then I will get a refund as tail would fall to approx 21K. 43444

Insured's Name:	Roger Coron, MD		
Policy Number:	18936		
Date of Termination:	January 1, 2014		
Date of Mailing:	April 10, 2014		
Territory:	PH01	Rate:	Full Time
Limits:	1.3M/3.9M	Period of Coverage:	07/01/2012 - 01/01/2014
Class:	PHY90A	Due Date:	05/10/2014
Specialty:	Gastroenterology		
Full Tail Premium:	$24,989.00		

Joe

Option 1

You may remit the full amount within the greater of sixty (60) days from the date of termination or thirty (30) days from the date of mailing of this notice.

Option 2

You may pay this amount over a two year period as follows:

* Payment 1 in the amount of $ 8,330.00 is due within the greater of sixty (60) days from the date of termination or thirty (30) days from the date of mailing of this notice.
* Payment 2 is due on 01/01/2015 and will be negotiated with your bank on or about that date.
* Payment 3 is due on 01/01/2016 and will be negotiated with your bank on or about that date.

If you would like to pay in installments, please contact the Underwriting Department immediately for the negotiable bank notes for payments two and three. The completed notes and your check for payment MUST be received by PRI by 05/10/2014.

See above

The notes will be negotiated through your bank on the due dates, with interest at 11%.

Please contact the Underwriting Department if you have any questions.

Physicians' Reciprocal Insurers

1800 Northern Boulevard, P. O. Box 9007, Roslyn, New York 11576

(516) 365-6690
(800) 632-6040
www.pri.com

April 10, 2014

Roger Coron, MD
37 Carrington Drive
Greenwich, CT 06831

Re: Policy Number 18936

Dear Dr. Coron:

Enclosed please find a bill for extended reporting coverage (tail) which conforms to the current billing schedule for tail set forth in Regulation 121 of the New York Insurance Department. You are reminded that your Claims-Made policy covered claims actually made and incidents reported within the policy period. All such coverage ceases upon cancellation and, in the absence of extended reporting coverage (tail), there is no further coverage after sixty (60) days from the date of cancellation.

Please be advised that you may remit either the entire balance of the tail premium within the greater of sixty (60) days from the date of cancellation or thirty (30) days from the date of mailing of this notice. Or, you may pay this amount over a two year period by remitting one third of the tail premium (payment 1) within the greater of sixty (60) days from the date of cancellation or thirty (30) days from the date of mailing of this notice. If you elect to remit one third of the tail premium due, an accrued interest charge of eleven percent (11%) will be added to the two remaining unpaid installments for tail and the amounts outstanding will be negotiated with your bank through two bank notes.

If you would like to pay in installments, please contact the Underwriting Department immediately for the bank notes. The completed notes and your check for payment must be received by PRI by the date indicated on the enclosed tail coverage premium notice.

If you have any question regarding this matter, please do not hesitate to contact our office.

Sincerely,

William E. Martin

William E. Martin, Director of Underwriting
Administrators for the Professions, Inc.
Attorney-in-Fact for
Physicians' Reciprocal Insurers

Attn Michael Botman

Physicians' Reciprocal Insurers
1800 Northern Boulevard, P. O. Box 9007, Roslyn, New York 11576

(516) 365-6690
(800) 632-6040
www.pri.com

April 10, 2014

Roger Coron, MD
37 Carrington Drive
Greenwich, CT 06831

Re: Policy Number: 18936

Dear Dr. Coron:

Please be advised that the above policy has been cancelled effective January 1, 2014.

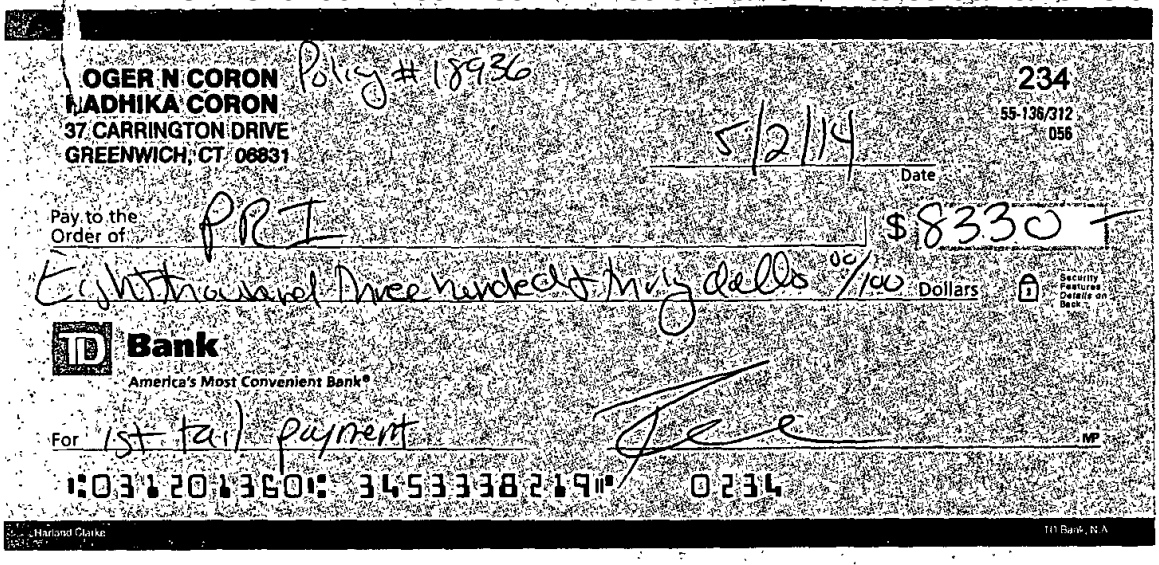
If you have any questions regarding this matter, please do not hesitate to contact our Underwriting Department.

A refund check is currently being processed. Should it not be received within twenty days of receipt of this letter, please contact our Underwriting Department

Very truly yours,

William E. Martin

William E. Martin, Director of Underwriting
Administrators for the Professions, Inc.
Attorney-in-Fact for
Physicians' Reciprocal Insurers



OGER N CORON
ADHIKA CORON
37 CARRINGTON DRIVE
GREENWICH, CT 06831

Poly #18936

234
55-136/312
056

5/2/14
Date

Pay to the Order of PRI

$ 8330 00

Eight thousand three hundred thirty dollars 00/100 Dollars

Security Features Details on Back

TD Bank
America's Most Convenient Bank®

For 1st tail payment

MP

⑆031201360⑆ 3453338219⑈ 0234

Harland Clarke

TD Bank, N.A.

Physicians' Reciprocal Insurers

1800 Northern Boulevard, P. O. Box 9007, Roslyn, New York 11576

(516) 365-6690
(800) 632-6040
www.pri.com

May 8, 2014

Roger Coron, MD
37 Carrington Drive
Greenwich, CT 06831

Re: Policy Number 18936

Dear Dr. Coron:

Our office is in receipt of payment in the amount of $8,330.00 for the first installment of tail. Please be advised that prior to confirming Tail coverage, PRI will need the following:

- Completed promissory notes with your bank's name and address on the line after the word "at" along with your bank account number on both notes.

These complete notes will be negotiated through your bank on the due dates, along with interest of 11%. Kindly remit the above requested information within 10 days from the date of this mailing. **Please be sure to provide your name, and social security number on the bottom portion of both notes as well.** Should you have any questions, please do not hesitate to contact our office.

Very truly yours,

Joseph Ferretti, Underwriter
Administrators for the Professions, Inc.
Attorney-in-Fact for
Physicians' Reciprocal Insurers

RIDGEWOOD PRINTING CO. (718) 386-3266

Insured: Roger Coron, MD

Policy # 18936

Date: May 8 20 14

,330.00

e (12) months after date, for value received, I promise to pay to the order of *Physicians' Reciprocal Insurers,*
Northern Boulevard, Roslyn, New York 11576
Eight thousand three hundred thirty Dollars

TD Bank (Name of Bank) 1701 Route 70 east Cherry Hill NJ (Bank Address) 345333 8019 (Account#)

interest at 11 percent per annum.

note is one of a series of 2 notes of even date herewith aggregating $ 16,659 It is understood
agreed that in the event of the non-payment of any one of said series and such default continue for a period of ten days, then at the
ion of the holder of any of the said notes, all or any part of the remaining unpaid notes shall forthwith become due and payable. The
ure to assert this right shall not be deemed a waiver thereof.

o. 1 Due 1/1/2015

Signature of Promisor

Social Securtiy No. 140-70-8891

ease print or type:
ame of Promisor Roger Coron
ddress 37 Carrington Drive
Greenwich CT 06831

33495W

RIDGEWOOD PRINTING CO. (718) 386-3266

Named Insured: Roger Coron, MD

Policy # 18936

Date: May 8 20 14

$ 8,329.00

Twenty four (24) months after date, for value received, I promise to pay to the order of *Physicians' Reciprocal Insurers,*
1800 Northern Boulevard, Roslyn, New York 11576
Eight thousand three hundred twenty nine Dollars

at TD Bank (Name of Bank) 1701 Route 70 east Cherry Hill NJ (Bank Address) 345333 8219 (Account#)

with interest at 11 percent per annum.

This note is one of a series of 2 notes of even date herewith aggregating $ 16,659 It is understood
and agreed that in the event of the non-payment of any one of said series and such default continue for a period of ten days, then at the
option of the holder of any of the said notes, all or any part of the remaining unpaid notes shall forthwith become due and payable. The
failure to assert this right shall not be deemed a waiver thereof.

No. 2 Due 1/1/2016

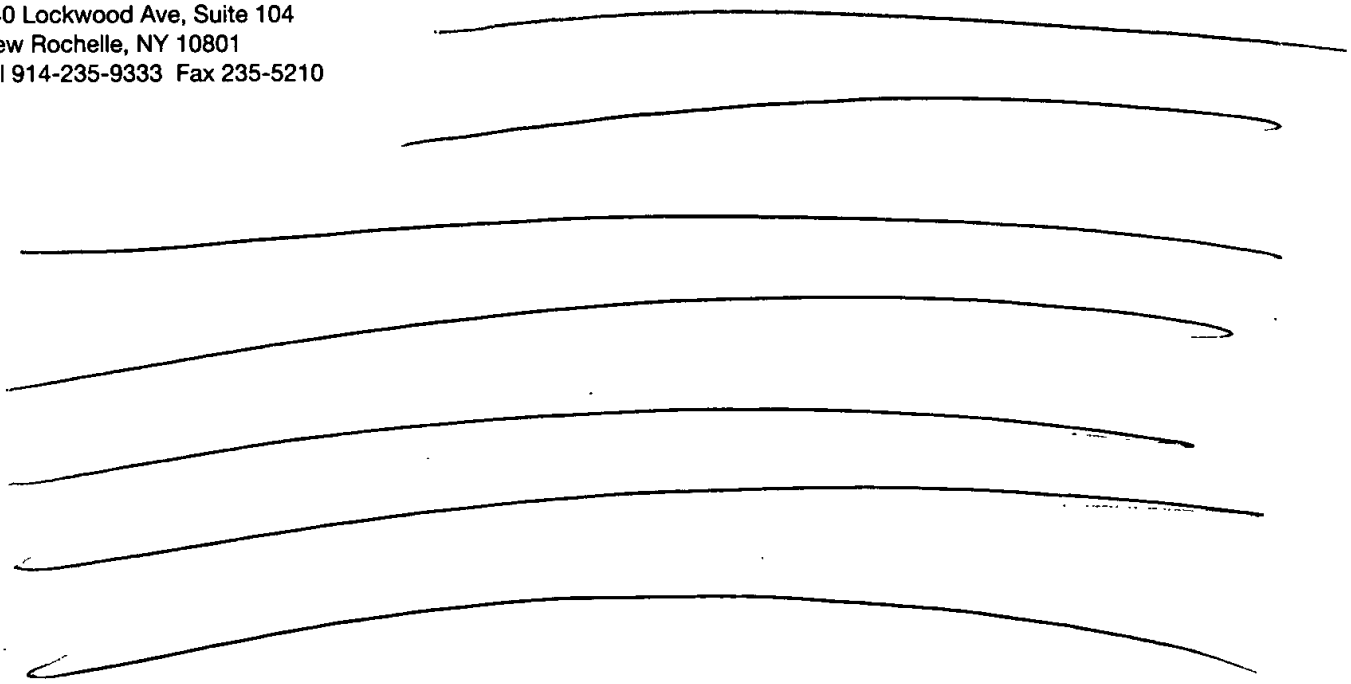
Signature of Promisor

Social Securtiy No. 140-70-8891

Please print or type:
Name of Promisor Roger Coron
Address 37 Carrington Drive
Greenwich CT 06831

Roger N. Coron, M.D.

GI & Hepatobiliary Diseases
140 Lockwood Ave, Suite 104
New Rochelle, NY 10801
Tel 914-235-9333 Fax 235-5210



13-22840-rdd Doc 1139-4 Filed 06/29/15 Entered 06/29/15 15:04:16 Claims (Part 2) Pg 10 of 21

Roger N. Coran, MD.
Montefiore New Rochelle
16 Guion Place
6th Floor
New Rochelle, NY 10801

7006 2150 0001 0952 7300

neopost
05/21/2014
US POSTAGE $007.40
FIRST-CLASS MAIL
ZIP 10801
041L12203224

Sound Shore Medical of Westchester
et al c/o GCG, Inc.
5151 Blazer Parkway, Ste A
Dublin, OH
43017

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)
DIVERSIFIED INFORMATION TECHNOLOGIES, 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.

THE GARDEN CITY GROUP, INC. FEB 22 2014

Name and Addresses Where Notices Should be Sent:
123 WYOMING AVE
SCRANTON PA 18503
ATTN: JULIE CALABRO, CONTROLLER

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:
C304

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): 5/31/13 - 10/31/13

3. DESCRIPTION OF CLAIM (IF KNOWN): RECORDS STORAGE

FILED - 01466
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1352.52 (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: JULIE CALABRO
Title: CONTROLLER
Company: _____
Address and telephone number (if different from notice address above):
SAME
Telephone number: 570-343-2300, EXT 3007

Julie Calabro (Signature) 1/31/14 (Date)

email: jcalabro@divintech.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.

Diversified
INFORMATION TECHNOLOGIES

INVOICE

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
JUNE
Activity for the Month of
MAY
C304

Billing Date
MAY 31,2013
Due Date
JUNE 30,2013
Invoice #
523522

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	**STORAGE**		
469.00	HARD COPY	.422	197.92
**	**SPECIAL SERVICE(NON TAXABLE)**		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

MDITINV

USD

Diversified
INFORMATION TECHNOLOGIES

INVOICE

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
JULY
Activity for the Month of
JUNE
C304

Billing Date
JUNE 30,2013
Due Date
JULY 30,2013
Invoice #
524228

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	STORAGE		
469.00	HARD COPY	.422	197.92
**	SPECIAL SERVICE(NON TAXABLE)		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

MDITINV

USD

Diversified
INFORMATION TECHNOLOGIES

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

INVOICE

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
AUGUST
Activity for the Month of
JULY
C304

Billing Date
JULY 31,2013
Due Date
AUGUST 30,2013
Invoice #
524714

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	STORAGE		
469.00	HARD COPY	.422	197.92
**	SPECIAL SERVICE(NON TAXABLE)		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

USD

Diversified
INFORMATION TECHNOLOGIES

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

INVOICE

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
SEPTEMBER
Activity for the Month of
AUGUST
C304

Billing Date
AUGUST 31,2013
Due Date
SEPTEMBER 30,2013
Invoice #
525618

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	STORAGE		
469.00	HARD COPY	.422	197.92
**	SPECIAL SERVICE(NON TAXABLE)		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

MDITINV

USD

Diversified
INFORMATION TECHNOLOGIES

INVOICE

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
OCTOBER
Activity for the Month of
SEPTEMBER
C304

Billing Date
SEPTEMBER 30,2013
Due Date
OCTOBER 30,2013
Invoice #
526868

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	**STORAGE**		
469.00	HARD COPY	.422	197.92
**	**SPECIAL SERVICE(NON TAXABLE)**		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

MDITINV

USD

Diversified
INFORMATION TECHNOLOGIES

INVOICE

Raising expectations. Getting results.

123 Wyoming Avenue, Scranton, PA 18503
Telephone (570) 343-2300
Tax I.D. # 23-2259137

SOUND SHORE MEDICAL (INDEX)
ATTN:RHONDA RUEZ
CENTER OF WESTCHESTER
16 GUION PLACE
NEW ROCHELLE NY 10802

Storage for the Month of
NOVEMBER
Activity for the Month of
OCTOBER
C304

Billing Date
OCTOBER 31,2013
Due Date
NOVEMBER 30,2013
Invoice #
527320

*** Office Copy ***

Quantity	Description	Unit Price	Amount
**	STORAGE		
469.00	HARD COPY	.422	197.92
**	SPECIAL SERVICE(NON TAXABLE)		
1.00	CIRM ACCESS / ADMIN FEE	27.500	27.50

Taxable	Non-Taxable	Sales Tax		Invoice Total
.00	225.42	.00		225.42

MDITINV

USD

13-22840-rdd Doc 113934 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Pg 18 of 21

Diversified
INFORMATION TECHNOLOGIES
1244 Wyoming Ave., Scranton, PA 18503

UNITED STATES POSTAGE
PITNEY BOWES
02 1P $ 000.69⁰
0003214059 FEB 17 2014
MAILED FROM ZIP CODE 18503

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

43017$5982

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)
J. WILLIA DAVIS WOMEN'S CLUB

☐ 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:
J. WILLIA DAVIS WOMEN'S CLUB
P.O. BOX 1594
NEW ROCHELLE, N.Y. 10801

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

Claim Number (if known): _____

Dated: _____

THE GARDEN CITY GROUP INC. MAR 31 2014

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) TICKETS AND AD FOR ANNUAL LUNCHEON

2. DATE DEBT WAS INCURRED (IF KNOWN): MAY 17TH 2013

3. DESCRIPTION OF CLAIM (IF KNOWN):
10 TICKETS @70.00 and 7 full pg ad for $350.00 FOR Annual Luncheon on 5-16-2013

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1,000 (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: Beuenia Brown
Title: President
(Signature) Beuenia Brown (Date) 3-27-2014
Company: _____
Address and telephone number (if different from notice address above):
Beuenia Brown
120 Remington Pl.
New Rochelle New York 10801
Telephone number: 310-6487-636-4565 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 - 01478
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

F. Willia Davis Woman's Club, Inc.

President - **Honorable Beuenia M. Brown**

P.O. Box 1594 • North Avenue New Rochelle, NY 10802

Member: National Association of Colored Women Club, Inc.

The Oldest Black Women Organization in America

Theme: "Keeping The Torch Lit From Generation To Generation"

Founded 1909

March 27, 2014

OFFICERS:

First Vice President
Theresa Brown

Second Vice President
Edith Duarte-Wilson

Recording Secretary
Lillian Calland

Financial Secretary
Naomi Leake

Treasurer
Sheila Colin-Robinson

Parliamentarian
Julia M. Robinson

Chaplain
Mrs. Valerie Bedell

HONORARY MEMBERS:

Mr. & Mrs. Vincent Grawboski
Mr. & Mrs. Alan Inman
Mrs. Ethel Porter-Shaw*
Mrs. Esther Winard*

State President
Ms. Diane Johnson

Regional President
Ms. Andrea Brown

National President
Mrs. Evelyn Rising

To Whom It May Concern.

This is to Notify you that Sound Shore Medical Center is indebted To the Above Named Club in the Amount of $1,000 dollars for 10 Tickets $70.00 Each And a Full page ad for $350.00. Total Amount of Money owed is Listed Above.

The date: May 16, 2013
12.00 Noon
Venue: Gruentree Country Club
on Davenport Ave. New Rochelle, N.Y

Sincerely Yours
Beuenia Brown
President

* Denotes Deceased Member

13-22840-rdd Doc 1139-4 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 2) Pg 21 of 21

F. Willia Davis Woman's Club, Inc.
P.O. Box 1594, North Avenue
New Rochelle, NY 10802

WESTCHESTER
NY 105
27 MAR 13
PM 1 L

USA
FOREVER
86023 209 183500

Sound Share Medical of Westchester
% CGC, Inc.
P.O. Box 9982
Dublin, Ohio 43017-5982

43017598282

FILED - 0[illegible]
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	**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)
FREEDOM MEDICAL, 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.

THE GARDEN CITY GROUP, INC. APR 29 2014

Name and Addresses Where Notices Should be Sent:
FREEDOM MEDICAL, INC.
219 WELSH POOL ROAD
EXTON, PA 19341
NEIL EISENBERG - CORP. CR. MGR.

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:
4960

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): 9.2013 - 11.5.13

3. DESCRIPTION OF CLAIM (IF KNOWN): MEDICAL RENTALS

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: 14,461.00 (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: NEIL EISENBERG
Title: CORPORATE CREDIT MANAGER
Company: FREEDOM MEDICAL INC
Address and telephone number (if different from notice address above):

Telephone number: 800-739-9949 x170

Neil Eisenberg (Signature) 1/21/14 (Date)

email: neisenberg@freedommedical.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.

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 287792.5.8
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/21/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	130292	Respironics Bipap Vision 130292 Form: 192491	9/1/2013	9/30/2013	9.00	200.00	30	200.00

Comments:

SUBTOTAL	200.00
TOTAL ORDER	200.00
TOTAL DUE	**200.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3M

Customer _____ (Signature)
Nene Bonet (Printed)

Freedom Rep JAY (Signature)

Date and Time 5/21/13 : ___ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

3:45 pm TO 6:00 P

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue
New Form

Metro

Rental Contract (Starts) RC-192491

Contract # 287792
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:43 PM
Created by: ilaverde@freedommedical.com
5/21/2013 3:38:46 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
646-318-6811

SalesRep Metro - Steve Vaccacio
Track Num
ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00
Start Date Tuesday, May 21, 2013
Delv Date Tuesday, May 21, 2013
Ship Date Tuesday, May 21, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
130292	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	80464	3921||**1000003061||!||**1000015948	287792||583152	3921	E/N
102319	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	96850	3921||**1000003061||!||**1000015681	287792||583153	3921	E/N
140155	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	98510	3921||**1000003061||!||**1000060397	287792||583154	3921	E/N
140148	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	47997	3921||**1000003061||!||**1000060409	287792||583155	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00				287792||583156	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00				287792||583157	9347	N/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes
p/o # GIVEN BY FRANK HALL.

Enfinity Import Notes
ENTERED: Contract Number-287792

FREEDOM MEDICAL
CONSIDER IT DONE.™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.3.4

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	139276	Respironics Bipap Vision 139276	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	114915	Respironics Bipap Vision	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	107362	Respironics Bipap Vision 107362	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	142019	Respironics Bipap Vision	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
5	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 198338	9/30/2013	0.00	0.00	30	0.00
5	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form. 198338	9/30/2013	0.00	0.00	30	0.00

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL	1,000.00
TOTAL ORDER	1,000.00
TOTAL DUE	**1,000.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer
SUNISH JACOB (Signature)
(Printed)

Freedom Rep (Signature)

Date and Time 7/31/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-198338

Contract # 297681
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
9/4/2013 2:28:32 PM
Created by: tshappell@freedommedical.com
7/31/2013 12:22:24 PM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3910

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Wednesday, July 31, 2013
Delv Date Wednesday, July 31, 2013
Ship Date Wednesday, July 31, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CItvId	Price
110308	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114024	3921||**1000003061||!||**1000015949	297681||623830	3921	E/N
139276	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	93007	3921||**1000003061||!||**1000015838	297681||623831	3921	E/N
114915	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105240	3921||**1000003061||!||**1000068290	297681||623832	3921	E/N
107362	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	11133	3921||**1000003061||!||**1000015815	297681||623833	3921	E/N
142019	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	99132	3921||**1000003061||!||**1000060726	297681||623834	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	5.00	SO 6338			297681||623835	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	5.00	PENDING			297681||623836	9347	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor resp office Also p/u 1 840 vent,and 2 broken bipap visions

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-297681

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 306135.1.2
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 9/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	140193	Respironics Bipap Vision	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	107977	Respironics Bipap Vision 107977	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	134918	Respironics Bipap Vision 134918	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	139275	Respironics Bipap Vision 139275	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
4	.BL-3020-R	Lamtic Round Handle Patient Arm	9/24/2013 Form: 202881	9/30/2013	0.00	0.00	7	0.00
4	.O2 HOSE	Green O2 Hose	9/24/2013 Form: 202881	9/30/2013	0.00	0.00	7	0.00

Comments:

SUBTOTAL	252.00
TOTAL ORDER	252.00
TOTAL DUE	**252.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue
New Form

Metro

Rental Contract (Starts) RC-202881

Contract # 306135
CustomerPO NR176288
Reason New Rental

Current Status: Entered

Changed by: czinn@freedommedical.com
9/26/2013 2:04:52 PM
Created by: slaverde@freedommedical.com (M)
9/24/2013 11:30:12 AM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Angela Cortese
914-632-5000 ext 3913

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, September 24, 2013
Delv Date Tuesday, September 24, 2013
Ship Date Tuesday, September 24, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	Al	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
140193	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	98744	3921||**1000003061||!||**1000060453	306135||659217	3921	E/N
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	114707	3921||**1000003061||!||**1000015826	306135||659218	3921	E/N
134918	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	84801	3921||**1000003061||!||**1000015829	306135||659219	3921	E/N
139275	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	25716	3921||**1000003061||!||**1000015920	306135||659220	3921	E/N
.BL-3020-R	Patient Arm Round Handle-lamtic	0.00	0.00	0.00	0.00	4.00	Pending			306135||659221	9347	N/N
.O2 HOSE	Hose, O2, (Green)	0.00	0.00	0.00	0.00	4.00	Pending			306135||659222	6168	N/N

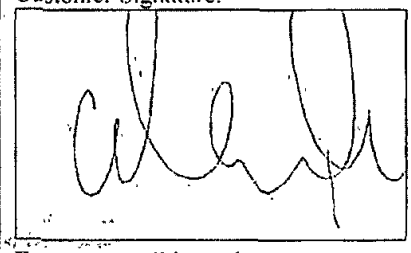
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

***Enfinity* Import Notes**
ENTERED: Contract Number-306135

Customer Signature:



Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Delivered By: Snyder Laverde
Delivery Date: 9/24/2013 11:34:41 AM

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285162.5.9

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/8/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	138239	Respironics Bipap Vision 138239	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	140144	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	133963	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	142152	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	140143	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	126362	Respironics Bipap Vision 126362	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	135640	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	114386	Respironics Bipap Vision 114386	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	134929	Respironics Bipap Vision 134929	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	110462	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	112189	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
13	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 188977	9/30/2013	0.00	0.00	30	0.00
13	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 188977	9/30/2013	0.00	0.00	30	0.00

Comments:

please deliver to Receiving dept.

SUBTOTAL	2,200.00
TOTAL ORDER	2,200.00
TOTAL DUE	**2,200.00**

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**285162.5.9**
INVOICE DATE:	9/30/2013
DUE DATE:	10/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 188977

Delivery/Pickup Ticket

● Delivery ○ Pickup ○ Rent ○ Sale ○ Service

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Med. Contact FRANK HALL

Street 16 Guion Place City _____ State __ Zip _____ Phone 914-365-3893

New Rochelle, NY 10801

Qty	Description	Serial / Part Number	Control Number
10	BiPAP VISIONS	138239	34537
		140144	98518
		130503	83938
		133963	47998
		142152	98550
		140143	98514
		121519	108780
		126362	35383
		117284	108782
		135640	105458

10 - O2 Hoses - Green

10 - Patient Arms.

Comments

Customer

(Signature)

R.D. LUNDE (15)

(Printed)

Freedom Medical Rep

(Signature)

Date and Time 4/8/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-188977

Contract # 280844
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:02:32 PM
Created by: ilaverde@freedommedical.com
4/9/2013 9:08:31 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3893

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 08, 2013
Delv Date Monday, April 08, 2013

Ship Date Tuesday, April 09, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
138239	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	34537	3921||**1000003061||!||**1000015936	280844||555614	3921	E/Y
140144	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98518	3921||**1000003061||!||**1000060405	280844||555615	3921	E/Y
130503	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	83938	3921||**1000003061||!||**1000015957	280844||555616	3921	E/Y
133963	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	47998	3921||**1000003061||!||**1000060395	280844||555617	3921	E/Y
142152	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98550	3921||**1000003061||!||**1000061369	280844||555618	3921	E/Y
140143	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98514	3921||**1000003061||!||**1000060401	280844||555619	3921	E/Y
121519	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108780	3921||**1000003061||!||**1000080001	280844||555620	3921	E/Y
126362	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	35383	3921||**1000003061||!||**1000016109	280844||555621	3921	E/Y
117284	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108782	3921||**1000003061||!||**1000080003	280844||555622	3921	E/Y
135640	Respironics Bipap	9.00	0.00	200.00	0.00	1.00	SO 6338	105458	3921||**1000003061||!	280844||555623	3921	E/Y

	Vision								||**1000068581			
114386	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	81211	3921||**1000003061||!||**1000016031	280844||555624	3921	E/Y
134929	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	84808	3921||**1000003061||!||**1000015742	280844||555625	3921	E/Y
123758	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	79122	3921||**1000003061||!||**1000016010	280844||555626	3921	E/Y
110462	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108781	3921||**1000003061||!||**1000080002	280844||555627	3921	E/Y
112189	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	107509	3921||**1000003061||!||**1000070443	280844||555628	3921	E/Y
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555629	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555630	9347	N/N

Comments **Patient Name:**
Room Number:
please deliver to Receiving dept.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-280844

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285166.5.7
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/29/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option 3510071045	9/1/2013 Form: 190647	9/30/2013	44.00	995.00	30	995.00
1	0717091077	Puritan Bennett840 Graphicuser Interface 0717091077	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00
1	0716001053	Puritan Bennett 802 Pbs Battery Pack 0716001053	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00
1	3511070417	Puritan Bennett 806 Compressor 3511070417	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00
1	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00
1	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00
1	.AIR HOSE	Yellow Air Hose	9/1/2013 Form: 190647	9/30/2013	0.00	0.00	30	0.00

Comments:
deliver to 3rd floor respiratory please.

SUBTOTAL	995.00
TOTAL ORDER	995.00
TOTAL DUE	**995.00**

REMIT TO:
Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer Carolyn Cummings (Signature)
Carolyn Cummings (Printed)

Freedom Rep JAY (Signature)

Date and Time 4/29/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

4:55P TO 7:00P

$ 44.00-day

$ 995.00-monthly

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-190647

Contract # 284776
CustomerPO PENDING
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:03:18 PM
Created by: tshappell@freedommedical.com
4/29/2013 4:47:19 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-560-6554

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 29, 2013
Delv Date Monday, April 29, 2013
Ship Date Monday, April 29, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
3510071045	Puritan Bennett 840 W/RM.PAV VV+ Option	44.00	0.00	995.00	0.00	1.00	PENDING	95870	3840||**1000002980||!||**1000013808	284776||571139	3840	N/Y
0717091077	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	95869	3833||**1000002973||!||**1000013040	284776||571140	3833	N/N
0716001053	Puritan Bennett 802 Pbs Battery Pack	0.00	0.00	0.00	0.00	1.00	PENDING	95871	4559||**1000003699||!||**1000023834	284776||571141	4559	N/N
3511070417	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	95989	4003||**1000003143||!||**1000016953	284776||571142	4003	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571143	9347	N/N
3510021663	Puritan Bennett 840 Ventilator	44.00	0.00	995.00	0.00	1.00	PENDING	114754	3834||**1000002974||!||**1000013199	284776||571144	3834	F/Y
02-170-91609	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	114753	3833||**1000002973||!||**1000012923	284776||571145	3833	N/N
02-160-01655	Puritan Bennett 802 Power	0.00	0.00	0.00	0.00	1.00	PENDING	114752	4558||**1000003698||!||**1000023724	284776||571146	4558	N/N

	Backup Source											
3511020894	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	17018	4003||**1000003143||!||**1000016942	284776||571147	4003	N/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571148	6168	N/N
.AIR HOSE	Yellow Air Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571149	6167	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor respiratory please.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-284776

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 288613.5.8

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	113839	Respironics Bipap Vision	9/1/2013 Form: 193004	9/30/2013	9.00	200.00	30	200.00
2	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 193004	9/30/2013	0.00	0.00	30	0.00
2	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 193004	9/30/2013	0.00	0.00	30	0.00
1	130231	Respironics Bipap Vision 130231	9/1/2013 Form: 193004	9/30/2013	9.00	200 00	30	200.00

Comments:

SUBTOTAL	400.00
TOTAL ORDER	400.00
TOTAL DUE	**400.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date 5/24/13 Stop Date _____

PO Number NR176288 Reason _____

Customer Name SoundShore Medical Contact Nene

Street _____ City N. Rochelle, NY State _ Zip _____ Phone (914) 365-3910

Qty	Description	Serial / Part Number	Control Number
1	Bipap Vision	107977	114707
1	Bipap Vision	113834	105587
2	Pt arms		
2	O2 hoses.		

Comments

Customer _____ (Signature) _____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5/24/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharge listed on invoices related to this delivery of equipment.

3:35 P.M.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-193004

Contract # 288613
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:58 PM
Created by: ilaverde@freedommedical.com
5/28/2013 2:12:53 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-365-3910

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Friday, May 24, 2013
Delv Date Friday, May 24, 2013
Ship Date Tuesday, May 28, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114707	3921||**1000003061||!||**1000015826	288613||586578	3921	E/N
113839	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105587	3921||**1000003061||!||**1000069120	288613||586579	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00	SO 6338			288613||586580	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00	PENDING			288613||586581	9347	N/N
137873	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	98746	3921||**1000003061||!||**1000060455	288613||586582	3921	E/N
130231	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	75535	3921||**1000003061||!||**1000015887	288613||586583	3921	E/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-288613

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Freedom Medical (5)
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Exton, PA 19341
800-784-8849
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INVOICE

INVOICE# 289384.5.6
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/16/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	13100320AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18040825AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	13030048AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.08	30	140.08
1	18040491AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.08	30	140.08
1	13090142AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	11110460AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	13100067AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	11020025AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18040471AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18010392AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
10	.15249A-MA	Cord, Bolus	9/1/2013 Form: 192111	9/30/2013	0.00	0.00	30	0.00
10		Keys	9/1/2013 Form: 192111	9/30/2013	0.00	0.00	30	0.00

Comments:

SUBTOTAL	1,404.00
TOTAL ORDER	1,404.00
TOTAL DUE	**1,404.00**

FREEDOM MEDICAL
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Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**289384.5.6**
INVOICE DATE:	9/30/2013
DUE DATE:	10/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-192111

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverde@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013
Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y

.15249A-MA	Cord, Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N
	Keys	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589463	9741	N/N

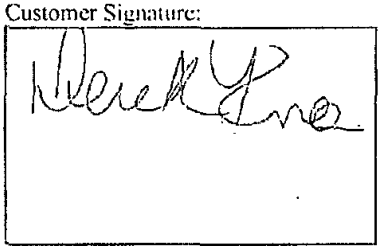
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

FREEDOM MEDICAL
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219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.4.5
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	10/1/2013 Form: 198338	10/31/2013	9.00	200.00	31	200.00
1	139276	Respironics Bipap Vision 139276	10/1/2013 Form: 198338	10/31/2013	9.00	200.00	31	200.00
1	114915	Respironics Bipap Vision	10/1/2013 Form: 198338	10/31/2013	9.00	200.00	31	200.00
1	107362	Respironics Bipap Vision 107362	10/1/2013 Form: 198338	10/31/2013	9.00	200.00	31	200.00
1	142019	Respironics Bipap Vision	10/1/2013 Form: 198338	10/31/2013	9.00	200.00	31	200.00
5	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 198338	10/31/2013	0.00	0.00	31	0.00
5	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 198338	10/31/2013	0.00	0.00	31	0.00

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL	1,000.00
TOTAL ORDER	1,000.00
TOTAL DUE	**1,000.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer
SUNISH JACOB (Signature)
(Printed)

Freedom Rep (Signature)

Date and Time 7/31/13 : AM PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro.

Rental Contract (Starts) RC-198338

Contract # 297681
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
9/4/2013 2:28:32 PM
Created by: tshappell@freedommedical.com
7/31/2013 12:22:24 PM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3910

SalesRep Metro - Steve Vaccacio
Track Num
ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00
Start Date Wednesday, July 31, 2013
Delv Date Wednesday, July 31, 2013
Ship Date Wednesday, July 31, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
110308	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114024	3921||**1000003061||!||**1000015949	297681||623830	3921	E/N
139276	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	93007	3921||**1000003061||!||**1000015838	297681||623831	3921	E/N
114915	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105240	3921||**1000003061||!||**1000068290	297681||623832	3921	E/N
107362	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	11133	3921||**1000003061||!||**1000015815	297681||623833	3921	E/N
142019	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	99132	3921||**1000003061||!||**1000060726	297681||623834	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	5.00	SO 6338			297681||623835	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	5.00	PENDING			297681||623836	9347	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor resp office Also p/u 1 840 vent,and 2 broken bipap visions

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-297681

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 306135.2.3
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 9/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	140193	Respironics Bipap Vision	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	107977	Respironics Bipap Vision 107977	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	134918	Respironics Bipap Vision 134918	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	139275	Respironics Bipap Vision 139275	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
4	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 202881	10/31/2013	0.00	0.00	31	0.00
4	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 202881	10/31/2013	0.00	0.00	31	0.00

Comments:

SUBTOTAL	800.00
TOTAL ORDER	800.00
TOTAL DUE	**800.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-202881

Contract # 306135
CustomerPO NR176288
Reason New Rental

Current Status: Entered

Changed by: czinn@freedommedical.com
9/26/2013 2:04:52 PM
Created by: slaverde@freedommedical.com (M)
9/24/2013 11:30:12 AM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Angela Cortese
914-632-5000 ext 3913

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, September 24, 2013
Delv Date Tuesday, September 24, 2013
Ship Date Tuesday, September 24, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	Al	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
140193	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	98744	3921||**1000003061||!||**1000060453	306135||659217	3921	E/N
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	114707	3921||**1000003061||!||**1000015826	306135||659218	3921	E/N
134918	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	84801	3921||**1000003061||!||**1000015829	306135||659219	3921	E/N
139275	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	25716	3921||**1000003061||!||**1000015920	306135||659220	3921	E/N
.BL-3020-R	Patient Arm Round Handle-lamtic	0.00	0.00	0.00	0.00	4.00	Pending			306135||659221	9347	N/N
.O2 HOSE	Hose, O2, (Green)	0.00	0.00	0.00	0.00	4.00	Pending			306135||659222	6168	N/N

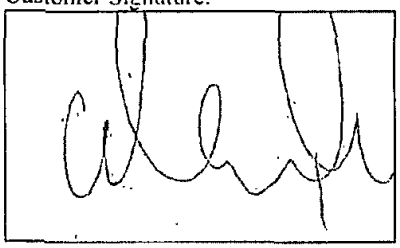
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-306135

Customer Signature:



Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Delivered By: Snyder Laverde
Delivery Date: 9/24/2013 11:34:41 AM

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285162.6.10
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/8/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	138239	Respironics Bipap Vision 138239	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	140144	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	133963	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	142152	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	140143	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	126362	Respironics Bipap Vision 126362	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	135640	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	114386	Respironics Bipap Vision 114386	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	134929	Respironics Bipap Vision 134929	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	110462	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	112189	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
13	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 188977	10/31/2013	0.00	0.00	31	0.00
13	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 188977	10/31/2013	0.00	0.00	31	0.00

Comments:

please deliver to Receiving dept.

SUBTOTAL	2,200.00
TOTAL ORDER	2,200.00
TOTAL DUE	**2,200.00**

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**285162.6.10**
INVOICE DATE:	10/31/2013
DUE DATE:	11/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

	Vision								||**1000068581			
114386	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	81211	3921||**1000003061||!||**1000016031	280844||555624	3921	E/Y
134929	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	84808	3921||**1000003061||!||**1000015742	280844||555625	3921	E/Y
123758	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	79122	3921||**1000003061||!||**1000016010	280844||555626	3921	E/Y
110462	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108781	3921||**1000003061||!||**1000080002	280844||555627	3921	E/Y
112189	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	107509	3921||**1000003061||!||**1000070443	280844||555628	3921	E/Y
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555629	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555630	9347	N/N

Comments **Patient Name:**
Room Number:
please deliver to Receiving dept.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-280844

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 287792.6.9
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/21/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	130292	Respironics Bipap Vision 130292 Form: 192491	10/1/2013	10/31/2013	9.00	200.00	31	200.00

Comments:

SUBTOTAL	200.00
TOTAL ORDER	200.00
TOTAL DUE	**200.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3 MD

Customer _____ (Signature)
Nene Kamat (Printed)

Freedom Rep Jay (Signature)

Date and Time 5/21/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

3:45 pm TO 6:00 P

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-192491

Contract #: 287792
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:43 PM
Created by: ilaverde@freedommedical.com
5/21/2013 3:38:46 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
646-318-6811

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, May 21, 2013
Delv Date Tuesday, May 21, 2013
Ship Date Tuesday, May 21, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
130292	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	80464	3921||**1000003061||!||**1000015948	287792||583152	3921	E/N
102319	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	96850	3921||**1000003061||!||**1000015681	287792||583153	3921	E/N
140155	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	98510	3921||**1000003061||!||**1000060397	287792||583154	3921	E/N
140148	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	47997	3921||**1000003061||!||**1000060409	287792||583155	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00				287792||583156	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00				287792||583157	9347	N/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes
p/o # GIVEN BY FRANK HALL.

Enfinity Import Notes
ENTERED: Contract Number-287792

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285166.6.8
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/29/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option 3510071045	10/1/2013 Form: 190647	10/31/2013	44.00	995.00	31	995.00
1	0717091077	Puritan Bennett840 Graphicuser Interface 0717091077	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	0716001053	Puritan Bennett 802 Pbs Battery Pack 0716001053	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	3511070417	Puritan Bennett 806 Compressor 3511070417	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.AIR HOSE	Yellow Air Hose	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00

Comments:
deliver to 3rd floor respiratory please.

SUBTOTAL	995.00
TOTAL ORDER	995.00
TOTAL DUE	**995.00**

REMIT TO:
Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer
Carolyn Current
(Signature)
(Printed)

Freedom Rep
JAY
(Signature)

Date and Time
4/29/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

4:55P TO 7:00P

$ 44.00 - day

$ 995.00 - monthly

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-190647

Contract # 284776
CustomerPO PENDING
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:03:18 PM
Created by: tshappell@freedommedical.com
4/29/2013 4:47:19 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-560-6554

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 29, 2013
Delv Date Monday, April 29, 2013
Ship Date Monday, April 29, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnfItvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option	44.00	0.00	995.00	0.00	1.00	PENDING	95870	3840||**1000002980||!||**1000013808	284776||571139	3840	N/Y
0717091077	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	95869	3833||**1000002973||!||**1000013040	284776||571140	3833	N/N
0716001053	Puritan Bennett 802 Pbs Battery Pack	0.00	0.00	0.00	0.00	1.00	PENDING	95871	4559||**1000003699||!||**1000023834	284776||571141	4559	N/N
3511070417	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	95989	4003||**1000003143||!||**1000016953	284776||571142	4003	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571143	9347	N/N
3510021663	Puritan Bennett 840 Ventilator	44.00	0.00	995.00	0.00	1.00	PENDING	114754	3834||**1000002974||!||**1000013199	284776||571144	3834	E/Y
02-170-91609	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	114753	3833||**1000002973||!||**1000012923	284776||571145	3833	N/N
02-160-01655	Puritan Bennett 802 Power	0.00	0.00	0.00	0.00	1.00	PENDING	114752	4558||**1000003698||!||**1000023724	284776||571146	4558	N/N

	Backup Source											
3511020894	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	17018	4003||**1000003143||!||**1000016942	284776||571147	4003	N/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571148	6168	N/N
.AIR HOSE	Yellow Air Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571149	6167	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor respiratory please.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-284776

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 288613.6.9
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	113839	Respironics Bipap Vision	10/1/2013 Form: 193004	10/31/2013	9.00	200.00	31	200.00
2	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 193004	10/31/2013	0.00	0.00	31	0.00
2	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 193004	10/31/2013	0.00	0.00	31	0.00
1	130231	Respironics Bipap Vision 130231	10/1/2013 Form: 193004	10/31/2013	9.00	200.00	31	200.00

Comments:

SUBTOTAL	400.00
TOTAL ORDER	400.00
TOTAL DUE	**400.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

RC 193004 242

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC 193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NE176288 Reason _____

Customer Name Sound Shore Contact NENE

Street _____ City _____ State __ Zip _____ Phone 914-365-3910

Qty	Description	Serial / Part Number	Control Number
(1)	Bi PAP Vision	137873	98746
1	Hose Green		
1	ARM		
(1)	Bi PAP Vision	130231	75535
1	Hose Green		
1	ARM		

RESPIRATORY 3TH FLOOR

Comments

Customer _____ (Signature)

_____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5/24/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above lifted equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-193004

Contract # 288613
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:58 PM
Created by: ilaverde@freedommedical.com
5/28/2013 2:12:53 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-365-3910

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Friday, May 24, 2013
Delv Date Friday, May 24, 2013
Ship Date Tuesday, May 28, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114707	3921||**1000003061||!||**1000015826	288613||586578	3921	E/N
113839	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105587	3921||**1000003061||!||**1000069120	288613||586579	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00	SO 6338			288613||586580	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00	PENDING			288613||586581	9347	N/N
137873	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	98746	3921||**1000003061||!||**1000060455	288613||586582	3921	E/N
130231	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	75535	3921||**1000003061||!||**1000015887	288613||586583	3921	E/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-288613

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 289384.6.7
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/16/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	13100320AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18040825AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	13030048AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.08	31	140.08
1	18040491AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.08	31	140.08
1	13090142AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	11110460AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	13100067AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	11020025AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18040471AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18010392AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
10	.15249A-MA	Cord, Bolus	10/1/2013 Form: 192111	10/31/2013	0.00	0.00	31	0.00
10		Keys	10/1/2013 Form: 192111	10/31/2013	0.00	0.00	31	0.00

Comments:

SUBTOTAL	1,404.00
TOTAL ORDER	1,404.00
TOTAL DUE	**1,404.00**

FREEDOM MEDICAL
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Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	289384.6.7
INVOICE DATE:	10/31/2013
DUE DATE:	11/30/2013
ACCOUNT#	4960
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-192111

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverde@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013
Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y

.15249A-MA	Cord. Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N
	Keys	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589463	9741	N/N

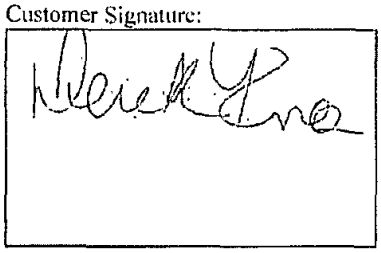
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.5.6
INVOICE DATE: 11/30/2013
DUE DATE: 12/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	139276	Respironics Bipap Vision 139276	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	114916	Respironics Bipap Vision	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	107362	Respironics Bipap Vision 107362	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	142019	Respironics Bipap Vision	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
5	.O2 HOSE	Green O2 Hose	11/1/2013 Form: 198338	11/5/2013	0.00	0.00	5	0.00
5	.BL-3020-R	Lamtic Round Handle Patient Arm	11/1/2013 Form: 198338	11/5/2013	0.00	0.00	5	0.00

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL 225.00
TOTAL ORDER 225.00

TOTAL DUE 225.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer
SUNISH 1408 (Signature)
(Printed)

Freedom Rep (Signature)

Date and Time 7/31/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written approval. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 306135.3.4

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 9/24/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	140193	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	107977	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	134918	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	139275	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
4	.02 HOSE	GREEN 02 HOSE						
4	.BI-3020-r	PATIENT ARM						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-202881

SUBTOTAL $180.00

TOTAL DUE $180.00

REMIT TO: Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-202881
Delv Date 9/24/2013
PO Number ~~Pending~~ NR 176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Angela Cortese
914-632-5000 ext 3913

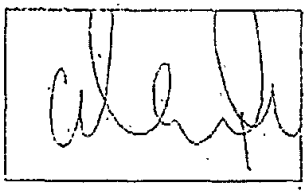
Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	140193	98744
1.00	Respironics Bipap Vision	107977	114707
1.00	Respironics Bipap Vision	134918	84801
1.00	Respironics Bipap Vision	139275	25716
4.00	Patient Arm Round Handle-lamtic	.BL-3020-R	
4.00	Hose, O2, (Green)	.O2 HOSE	

Comments **Patient Name:** **Room Number:**

Customer



Freedom Rep
Snyder Laverde

Date and Time
9/24/2013 11:34:41 AM

Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the *then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of* equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 285166.7.9

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 4/29/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	3510071045	PB 840 W/RM,PAV VV+ OPTION	11/1/2013	11/5/2013	$44.00	$995.00	5	$220.00
1	717091077	PB 840 GRAPHICUSER INTERFACE						
1	716001053	PB 802 BATTERY PACK						
1	3511070417	PB 806 COMPRESSOR						
1	.BL-3020-R	PATIENT ARM						
1	.02 HOSE	GREEN O2 HOSE						
1	.AIR HOSE	YELLOW AIR HOSE						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-190647

SUBTOTAL	$220.00
TOTAL DUE	$220.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
***Phone:* (201)791-0900**
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer Carolyn Cunningham (Signature)
Carolyn Cunningham (Printed)

Freedom Rep JA (Signature)

Date and Time 4/29/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of repair devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

4:55P TO 7:00P

$ 44.00-day

$ 995.00-monthly

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 287792.7.10

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/21/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	130292	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-192491

SUBTOTAL	$45.00
TOTAL DUE	$45.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental
Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3 MO

Customer _____ (Signature)
Nene Kamat (Printed)

Freedom Rep JAY (Signature)

Date and Time 5/21/13 : ___ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

3:45 pm TO 6:00 P

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 288613.7.10

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/24/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	113839	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	130231	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
2	.02 HOSE	GREEN 02 HOSE						
2	.BL-3020-R	PATIENT ARM						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-193004

SUBTOTAL	$90.00
TOTAL DUE	$90.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

(1-2)

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date 5/24/13 Stop Date _____

PO Number NR176288 Reason _____

Customer Name SoundShore Medical Contact Nene

Street _____ City N. Rochelle, NY State _ Zip _____ Phone (914) 365-3910

Qty	Description	Serial /.Part Number	Control Number
1	Bipap Vision	107977	114707
1	Bipap Vision	113834	105587
2	Pt arms		
2	O2 hoses.		

Comments

Customer (Signature) (Printed)

Freedom Medical Rep (Signature) Date and Time 5/24/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

3:35 P.M.

RC-
193004

242

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC
193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Contact Nene

Street _____ City _____ State __ Zip _____ Phone 914-365-3910

Qty	Description	Serial / Part Number	Control Number
(1)	Bi PAP Vision	137873	98746
1	Hose Green		
1	ARM		
(1)	Bi PAP Vision	130731	75535
1	Hose Green		
1	ARM		

RESPIRATORY 3TH FLOOR

Comments

Customer _____ (Signature)

_____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5/24/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 289384.7.8

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	*Ship To:*
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/16/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	13100320AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040825AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13030048AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040491AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13090142AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	11110460AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13100067AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	11020025AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040471AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18010392AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-192111

SUBTOTAL	$251.00
TOTAL DUE	$251.00

REMIT TO:

Freedom Medical Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Tick | Pick Ticket | Packing Slip | Email Receipt | New WorkQueu | New Form

Metro

Rental Contract (Starts) **RC-192111**

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverdc@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)

4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013

Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnfIlvltId	EnfTTnlvHdRntId	EnfT CllvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y
.15249A-MA	Cord, Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N

	Keys	0.00	0.00	0.00	0.00	10.00	NR176990		289384	589463	9741	N/N

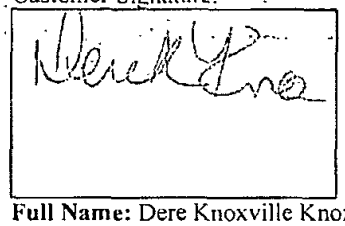
Comments **Patient Name:** **Room Number:**

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

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)
FREEDOM MEDICAL, 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.

THE GARDEN CITY GROUP, INC. DEC 12 2014

Name and Addresses Where Notices Should be Sent:
FREEDOM MEDICAL, INC.
219 WELSH POOL ROAD
EXTON, PA 19341
NEIL EISENBERG - CORP. CR. MGR.

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:
4960

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): 9/30/13 - 11/5/13

3. DESCRIPTION OF CLAIM (IF KNOWN):
MEDICAL RENTALS

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $14,461.00
(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: NEIL EISENBERG
Title: CORPORATE CREDIT MANAGER
Company: FREEDOM MEDICAL, INC

Neil Eisenberg (Signature) 1/21/14 (Date)

Address and telephone number (if different from notice address above):

Telephone number: 800-734-9341 x170 email: neisenberg@freedommedical.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 - 01528
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 287792.5.8
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/21/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	130292	Respironics Bipap Vision 130292 Form: 192491	9/1/2013	9/30/2013	9.00	200.00	30	200.00

Comments:

SUBTOTAL	200.00
TOTAL ORDER	200.00
TOTAL DUE	**200.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental
Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3M

Customer (Signature)

Nene Komet (Printed)

Freedom Rep JAY (Signature)

Date and Time 5/21/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

3:45 pm TO 6:00 P

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-192491

Contract # 287792
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:43 PM
Created by: ilaverde@freedommedical.com
5/21/2013 3:38:46 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
646-318-6811

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, May 21, 2013
Delv Date Tuesday, May 21, 2013
Ship Date Tuesday, May 21, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
130292	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	80464	3921||**1000003061||!||**1000015948	287792||583152	3921	E/N
102319	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	96850	3921||**1000003061||!||**1000015681	287792||583153	3921	E/N
140155	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	98510	3921||**1000003061||!||**1000060397	287792||583154	3921	E/N
140148	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	47997	3921||**1000003061||!||**1000060409	287792||583155	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00				287792||583156	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00				287792||583157	9347	N/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes
p/o # GIVEN BY FRANK HALL.

Enfinity Import Notes
ENTERED: Contract Number-287792

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.3.4
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	139276	Respironics Bipap Vision 139276	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	114915	Respironics Bipap Vision	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	107362	Respironics Bipap Vision 107362	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
1	142019	Respironics Bipap Vision	9/1/2013 Form: 198338	9/30/2013	9.00	200.00	30	200.00
5	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 198338	9/30/2013	0.00	0.00	30	0.00
5	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 198338	9/30/2013	0.00	0.00	30	0.00

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL	1,000.00
TOTAL ORDER	1,000.00
TOTAL DUE	**1,000.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer _____ (Signature)
SUNISH JACOB (Printed)

Freedom Rep _____ (Signature)

Date and Time 7/31/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-198338

Contract # 297681
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
9/4/2013 2:28:32 PM
Created by: tshappell@freedommedical.com
7/31/2013 12:22:24 PM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3910

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Wednesday, July 31, 2013
Delv Date Wednesday, July 31, 2013

Ship Date Wednesday, July 31, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
110308	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114024	3921||**1000003061||!||**1000015949	297681||623830	3921	E/N
139276	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	93007	3921||**1000003061||!||**1000015838	297681||623831	3921	E/N
114915	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105240	3921||**1000003061||!||**1000068290	297681||623832	3921	E/N
107362	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	11133	3921||**1000003061||!||**1000015815	297681||623833	3921	E/N
142019	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	99132	3921||**1000003061||!||**1000060726	297681||623834	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	5.00	SO 6338			297681||623835	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	5.00	PENDING			297681||623836	9347	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor resp office Also p/u 1 840 vent,and 2 broken bipap visions

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-297681

FREEDOM MEDICAL
CONSIDER IT DONE!

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 306135.1.2

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 9/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	140193	Respironics Bipap Vision	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	107977	Respironics Bipap Vision 107977	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	134918	Respironics Bipap Vision 134918	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
1	139275	Respironics Bipap Vision 139275	9/24/2013 Form: 202881	9/30/2013	9.00	200.00	7	63.00
4	.BL-3020-R	Lamtic Round Handle Patient Arm	9/24/2013 Form: 202881	9/30/2013	0.00	0 00	7	0.00
4	.O2 HOSE	Green O2 Hose	9/24/2013 Form: 202881	9/30/2013	0.00	0.00	7	0.00

Comments:

SUBTOTAL	252.00
TOTAL ORDER	252.00
TOTAL DUE	**252.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-202881

Contract # 306135
CustomerPO NR176288
Reason New Rental

Current Status: Entered

Changed by: czinn@freedommedical.com
9/26/2013 2:04:52 PM
Created by: slaverde@freedommedical.com (M)
9/24/2013 11:30:12 AM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Angela Cortese
914-632-5000 ext 3913

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, September 24, 2013
Delv Date Tuesday, September 24, 2013
Ship Date Tuesday, September 24, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
140193	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	98744	3921||**1000003061||!||**1000060453	306135||659217	3921	E/N
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	114707	3921||**1000003061||!||**1000015826	306135||659218	3921	E/N
134918	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	84801	3921||**1000003061||!||**1000015829	306135||659219	3921	E/N
139275	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	25716	3921||**1000003061||!||**1000015920	306135||659220	3921	E/N
.BL-3020-R	Patient Arm Round Handle-lamtic	0.00	0.00	0.00	0.00	4.00	Pending			306135||659221	9347	N/N
.O2 HOSE	Hose, O2, (Green)	0.00	0.00	0.00	0.00	4.00	Pending			306135||659222	6168	N/N

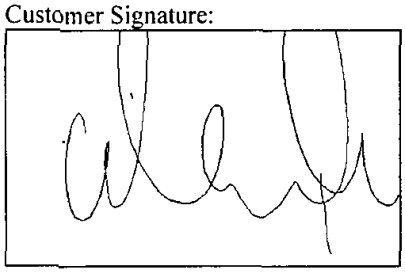
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-306135

Customer Signature:



Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Delivered By: Snyder Laverde
Delivery Date: 9/24/2013 11:34:41 AM

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285162.5.9
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/8/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	138239	Respironics Bipap Vision 138239	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	140144	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	133963	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	142152	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	140143	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	126362	Respironics Bipap Vision 126362	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	135640	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	114386	Respironics Bipap Vision 114386	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	134929	Respironics Bipap Vision 134929	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	110462	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
1	112189	Respironics Bipap Vision	9/1/2013 Form: 188977	9/30/2013	9.00	200.00	30	200.00
13	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 188977	9/30/2013	0.00	0.00	30	0.00
13	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 188977	9/30/2013	0.00	0.00	30	0.00

Comments:

please deliver to Receiving dept.

SUBTOTAL	2,200.00
TOTAL ORDER	2,200.00
TOTAL DUE	**2,200.00**

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**285162.5.9**
INVOICE DATE:	9/30/2013
DUE DATE:	10/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 188977

Delivery/Pickup Ticket

● Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Med. Contact FRANK HALL.

Street 16 Main City _____ State __ Zip _____ Phone 914-365-3893

place, New Rochelle, NY 10801

Qty	Description	Serial / Part Number	Control Number
10	BiPAP VISIONS	138239	34537
		140144	98518
		130503	83938
		133963	47998
		142152	98550
		140143	98514
		121519	108780
		126362	35383
		117284	108782
		135640	105458

10 - O2 Hoses - Green

10 - Patient Arms.

Comments

Customer
(Signature)
RD Lunde (15)
(Printed)

Freedom Medical Rep
(Signature)

Date and Time 4/8/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surchages listed on invoices related to this delivery of equipment.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-188977

Contract # 280844
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:02:32 PM
Created by: ilaverde@freedommedical.com
4/9/2013 9:08:31 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3893

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 08, 2013
Delv Date Monday, April 08, 2013

Ship Date Tuesday, April 09, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
138239	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	34537	3921||**1000003061||!||**1000015936	280844||555614	3921	E/Y
140144	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98518	3921||**1000003061||!||**1000060405	280844||555615	3921	E/Y
130503	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	83938	3921||**1000003061||!||**1000015957	280844||555616	3921	E/Y
133963	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	47998	3921||**1000003061||!||**1000060395	280844||555617	3921	E/Y
142152	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98550	3921||**1000003061||!||**1000061369	280844||555618	3921	E/Y
140143	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98514	3921||**1000003061||!||**1000060401	280844||555619	3921	E/Y
121519	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108780	3921||**1000003061||!||**1000080001	280844||555620	3921	E/Y
126362	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	35383	3921||**1000003061||!||**1000016109	280844||555621	3921	E/Y
117284	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108782	3921||**1000003061||!||**1000080003	280844||555622	3921	E/Y
135640	Respironics Bipap	9.00	0.00	200.00	0.00	1.00	SO 6338	105458	3921||**1000003061||!	280844||555623	3921	E/Y

	Vision								||**1000068581			
114386	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	81211	3921||**1000003061||!||**1000016031	280844||555624	3921	E/Y
134929	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	84808	3921||**1000003061||!||**1000015742	280844||555625	3921	E/Y
123758	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	79122	3921||**1000003061||!||**1000016010	280844||555626	3921	E/Y
110462	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108781	3921||**1000003061||!||**1000080002	280844||555627	3921	E/Y
112189	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	107509	3921||**1000003061||!||**1000070443	280844||555628	3921	E/Y
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555629	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555630	9347	N/N

Comments **Patient Name:**
Room Number:
please deliver to Receiving dept.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-280844

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285166.5.7

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/29/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option 3510071045	9/1/2013	9/30/2013	44.00	995.00	30	995.00
			Form: 190647					
1	0717091077	Puritan Bennett840 Graphicuser Interface 0717091077	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					
1	0716001053	Puritan Bennett 802 Pbs Battery Pack 0716001053	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					
1	3511070417	Puritan Bennett 806 Compressor 3511070417	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					
1	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					
1	.O2 HOSE	Green O2 Hose	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					
1	.AIR HOSE	Yellow Air Hose	9/1/2013	9/30/2013	0.00	0.00	30	0.00
			Form: 190647					

Comments:

deliver to 3rd floor respiratory please.

SUBTOTAL	995.00
TOTAL ORDER	995.00
TOTAL DUE	**995.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer Carolyn Currens (Signature)
Carolyn Currens (Printed)

Freedom Rep JAY (Signature)

Date and Time 4/29/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect of abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CarePusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

4:55P TO 7:00P

$ 44.00-day

$ 995.00-monthly

Show Menu | Delivery Ticket | Pick Ticket | Packing Slips | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-190647

Contract # 284776
CustomerPO PENDING
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:03:18 PM
Created by: tshappell@freedommedical.com
4/29/2013 4:47:19 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-560-6554

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 29, 2013
Delv Date Monday, April 29, 2013

Ship Date Monday, April 29, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option	44.00	0.00	995.00	0.00	1.00	PENDING	95870	3840||**1000002980||!||**1000013808	284776||571139	3840	N/Y
0717091077	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	95869	3833||**1000002973||!||**1000013040	284776||571140	3833	N/N
0716001053	Puritan Bennett 802 Pbs Battery Pack	0.00	0.00	0.00	0.00	1.00	PENDING	95871	4559||**1000003699||!||**1000023834	284776||571141	4559	N/N
3511070417	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	95989	4003||**1000003143||!||**1000016953	284776||571142	4003	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571143	9347	N/N
3510021663	Puritan Bennett 840 Ventilator	44.00	0.00	995.00	0.00	1.00	PENDING	114754	3834||**1000002974||!||**1000013199	284776||571144	3834	E/Y
02-170-91609	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	114753	3833||**1000002973||!||**1000012923	284776||571145	3833	N/N
02-160-01655	Puritan Bennett 802 Power	0.00	0.00	0.00	0.00	1.00	PENDING	114752	4558||**1000003698||!||**1000023724	284776||571146	4558	N/N

	Backup Source											
3511020894	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	17018	4003||**1000003143||!||**1000016942	284776||571147	4003	N/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571148	6168	N/N
.AIR HOSE	Yellow Air Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571149	6167	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor respiratory please.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-284776

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 288613.5.8
INVOICE DATE: 9/30/2013
DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	113839	Respironics Bipap Vision	9/1/2013 Form: 193004	9/30/2013	9.00	200.00	30	200.00
2	.O2 HOSE	Green O2 Hose	9/1/2013 Form: 193004	9/30/2013	0.00	0.00	30	0.00
2	.BL-3020-R	Lamtic Round Handle Patient Arm	9/1/2013 Form: 193004	9/30/2013	0.00	0 00	30	0.00
1	130231	Respironics Bipap Vision 130231	9/1/2013 Form: 193004	9/30/2013	9.00	200.00	30	200.00

Comments:

SUBTOTAL	400.00
TOTAL ORDER	400.00
TOTAL DUE	**400.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date 5/24/13 Stop Date _____

PO Number NR176288 Reason _____

Customer Name SoundShore Medical Contact Nene

Street _____ City _____ State __ Zip _____ Phone (914) 365-3910

N. Rochelle, NY

Qty	Description	Serial / Part Number	Control Number
1	Bipap Vision	107977	114707
1	Bipap Vision	113834	105587
2	Pt arms		
2	O2 hoses		

Comments

Customer _____ (Signature) _____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5/24/13 : ___ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surchages listed on invoices related to this delivery of equipment.

3:35 P.M.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-193004

Contract # 288613
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:58 PM
Created by: ilaverde@freedommedical.com
5/28/2013 2:12:53 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-365-3910

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Friday, May 24, 2013
Delv Date Friday, May 24, 2013

Ship Date Tuesday, May 28, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114707	3921||**1000003061||!||**1000015826	288613||586578	3921	E/N
113839	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105587	3921||**1000003061||!||**1000069120	288613||586579	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00	SO 6338			288613||586580	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00	PENDING			288613||586581	9347	N/N
137873	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	98746	3921||**1000003061||!||**1000060455	288613||586582	3921	E/N
130231	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	75535	3921||**1000003061||!||**1000015887	288613||586583	3921	E/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-288613

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 289384.5.6

INVOICE DATE: 9/30/2013

DUE DATE: 10/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/16/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	13100320AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18040825AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	13030048AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.08	30	140.08
1	18040491AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.08	30	140.08
1	13090142AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	11110460AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	13100067AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	11020025AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18040471AD	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
1	18010392AL	Baxter I Pump Upgraded	9/1/2013 Form: 192111	9/30/2013	5.02	140.48	30	140.48
10	.15249A-MA	Cord, Bolus	9/1/2013 Form: 192111	9/30/2013	0.00	0.00	30	0.00
10		Keys	9/1/2013 Form: 192111	9/30/2013	0.00	0.00	30	0.00

Comments:

SUBTOTAL	1,404.00
TOTAL ORDER	1,404.00
TOTAL DUE	**1,404.00**

FREEDOM MEDICAL
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Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**289384.5.6**
INVOICE DATE:	9/30/2013
DUE DATE:	10/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-192111

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverde@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013

Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y

.15249A-MA	Cord, Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N
	Keys	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589463	9741	N/N

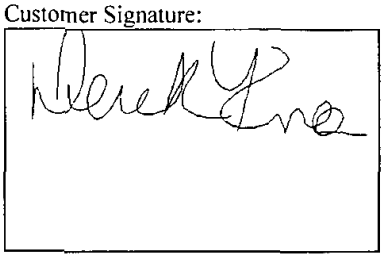
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

FREEDOM MEDICAL
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Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.4.5

INVOICE DATE: 10/31/2013

DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	10/1/2013	10/31/2013	9.00	200.00	31	200.00
			Form: 198338					
1	139276	Respironics Bipap Vision 139276	10/1/2013	10/31/2013	9.00	200.00	31	200.00
			Form: 198338					
1	114915	Respironics Bipap Vision	10/1/2013	10/31/2013	9.00	200.00	31	200.00
			Form: 198338					
1	107362	Respironics Bipap Vision 107362	10/1/2013	10/31/2013	9.00	200.00	31	200.00
			Form: 198338					
1	142019	Respironics Bipap Vision	10/1/2013	10/31/2013	9.00	200.00	31	200.00
			Form: 198338					
5	.O2 HOSE	Green O2 Hose	10/1/2013	10/31/2013	0.00	0.00	31	0.00
			Form: 198338					
5	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013	10/31/2013	0.00	0.00	31	0.00
			Form: 198338					

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL	1,000.00
TOTAL ORDER	1,000.00
TOTAL DUE	**1,000.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer

SUNISH JACOB (Signature)

(Printed)

Freedom Rep (Signature)

Date and Time 7/31/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-198338

Contract # 297681
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
9/4/2013 2:28:32 PM
Created by: tshappell@freedommedical.com
7/31/2013 12:22:24 PM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3910

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Wednesday, July 31, 2013
Delv Date Wednesday, July 31, 2013
Ship Date Wednesday, July 31, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnlvHdRntId	EnfT CIlvId	Price
110308	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114024	3921||**1000003061||!||**1000015949	297681||623830	3921	E/N
139276	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	93007	3921||**1000003061||!||**1000015838	297681||623831	3921	E/N
114915	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105240	3921||**1000003061||!||**1000068290	297681||623832	3921	E/N
107362	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	11133	3921||**1000003061||!||**1000015815	297681||623833	3921	E/N
142019	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	99132	3921||**1000003061||!||**1000060726	297681||623834	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	5.00	SO 6338			297681||623835	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	5.00	PENDING			297681||623836	9347	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor resp office Also p/u 1 840 vent,and 2 broken bipap visions

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-297681

FREEDOM MEDICAL
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Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 306135.2.3
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 9/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	140193	Respironics Bipap Vision	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	107977	Respironics Bipap Vision 107977	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	134918	Respironics Bipap Vision 134918	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
1	139275	Respironics Bipap Vision 139275	10/1/2013 Form: 202881	10/31/2013	9.00	200.00	31	200.00
4	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 202881	10/31/2013	0.00	0.00	31	0.00
4	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 202881	10/31/2013	0.00	0.00	31	0.00

Comments:

SUBTOTAL	800.00
TOTAL ORDER	800.00
TOTAL DUE	**800.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-202881

Contract # 306135
CustomerPO NR176288
Reason New Rental

Current Status: Entered

Changed by: czinn@freedommedical.com
9/26/2013 2:04:52 PM
Created by: slaverde@freedommedical.com (M)
9/24/2013 11:30:12 AM

Customer (4960)
4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Angela Cortese
914-632-5000 ext 3913

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, September 24, 2013
Delv Date Tuesday, September 24, 2013

Ship Date Tuesday, September 24, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
140193	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	98744	3921||**1000003061||!||**1000060453	306135||659217	3921	E/N
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	114707	3921||**1000003061||!||**1000015826	306135||659218	3921	E/N
134918	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	84801	3921||**1000003061||!||**1000015829	306135||659219	3921	E/N
139275	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	Pending	25716	3921||**1000003061||!||**1000015920	306135||659220	3921	E/N
.BL-3020-R	Patient Arm Round Handle-lamtic	0.00	0.00	0.00	0.00	4.00	Pending			306135||659221	9347	N/N
.O2 HOSE	Hose, O2, (Green)	0.00	0.00	0.00	0.00	4.00	Pending			306135||659222	6168	N/N

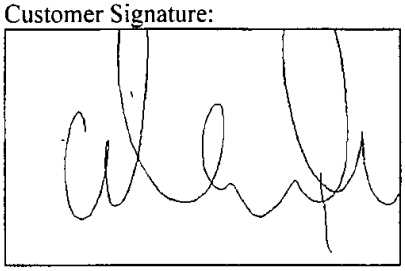
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-306135

Customer Signature:



Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Delivered By: Snyder Laverde
Delivery Date: 9/24/2013 11:34:41 AM

FREEDOM MEDICAL
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Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285162.6.10
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/8/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	138239	Respironics Bipap Vision 138239	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	140144	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	133963	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	142152	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	140143	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	126362	Respironics Bipap Vision 126362	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	135640	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	114386	Respironics Bipap Vision 114386	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	134929	Respironics Bipap Vision 134929	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	110462	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
1	112189	Respironics Bipap Vision	10/1/2013 Form: 188977	10/31/2013	9.00	200.00	31	200.00
13	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 188977	10/31/2013	0.00	0.00	31	0.00
13	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 188977	10/31/2013	0.00	0.00	31	0.00

Comments:

please deliver to Receiving dept.

SUBTOTAL	2,200.00
TOTAL ORDER	2,200.00
TOTAL DUE	**2,200.00**

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (50)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**285162.6.10**
INVOICE DATE:	10/31/2013
DUE DATE:	11/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC - 188977

Delivery/Pickup Ticket

● Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Med. Contact FRANK HALL.

Street 16 Union City _____ State __ Zip _____ Phone 914-365-3893

place New Rochelle, NY 10801

Qty	Description	Serial / Part Number	Control Number
10	BiPAP VISIONS	138239	34537
		140144	98518
		130503	83938
		133963	47998
		142152	98550
		140143	98514
		121519	108780
		126362	35383
		117284	108782
		135640	105458

10. O2 Hoses - Green

10. Patient Arms.

Comments

Customer

RD Lunde (Signature)

(Printed) 15

Freedom Medical Rep

(Signature)

Date and Time 4/8/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surchages listed on invoices related to this delivery of equipment.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-188977

Contract # 280844
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:02:32 PM
Created by: ilaverde@freedommedical.com
4/9/2013 9:08:31 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Frank Hall
914-365-3893

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 08, 2013
Delv Date Monday, April 08, 2013
Ship Date Tuesday, April 09, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT ClIvId	Price
138239	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	34537	3921||**1000003061||!||**1000015936	280844||555614	3921	E/Y
140144	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98518	3921||**1000003061||!||**1000060405	280844||555615	3921	E/Y
130503	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	83938	3921||**1000003061||!||**1000015957	280844||555616	3921	E/Y
133963	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	47998	3921||**1000003061||!||**1000060395	280844||555617	3921	E/Y
142152	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98550	3921||**1000003061||!||**1000061369	280844||555618	3921	E/Y
140143	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	98514	3921||**1000003061||!||**1000060401	280844||555619	3921	E/Y
121519	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108780	3921||**1000003061||!||**1000080001	280844||555620	3921	E/Y
126362	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	35383	3921||**1000003061||!||**1000016109	280844||555621	3921	E/Y
117284	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108782	3921||**1000003061||!||**1000080003	280844||555622	3921	E/Y
135640	Respironics Bipap	9.00	0.00	200.00	0.00	1.00	SO 6338	105458	3921||**1000003061||!	280844||555623	3921	E/Y

	Vision								||**1000068581			
114386	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	81211	3921||**1000003061||!||**1000016031	280844||555624	3921	E/Y
134929	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	84808	3921||**1000003061||!||**1000015742	280844||555625	3921	E/Y
123758	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	79122	3921||**1000003061||!||**1000016010	280844||555626	3921	E/Y
110462	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	108781	3921||**1000003061||!||**1000080002	280844||555627	3921	E/Y
112189	Respironics Bipap Vision	9.00	0.00	200.00	0.00	1.00	SO 6338	107509	3921||**1000003061||!||**1000070443	280844||555628	3921	E/Y
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555629	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	15.00	NR176288			280844||555630	9347	N/N

Comments **Patient Name:**
Room Number:
please deliver to Receiving dept.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-280844

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 287792.6.9
INVOICE DATE: 10/31/2013
DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/21/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	130292	Respironics Bipap Vision 130292 Form: 192491	10/1/2013	10/31/2013	9 00	200.00	31	200.00

Comments:

SUBTOTAL	200.00
TOTAL ORDER	200.00
TOTAL DUE	**200.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3 MD

Customer _____ (Signature)
Nene Ramos (Printed)

Freedom Rep JAY (Signature)

Date and Time 5/21/13 : ___ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

3:45 pm TO 6:00 P

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-192491

Contract # 287792
CustomerPO NR176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:43 PM
Created by: ilaverde@freedommedical.com
5/21/2013 3:38:46 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
646-318-6811

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Tuesday, May 21, 2013
Delv Date Tuesday, May 21, 2013
Ship Date Tuesday, May 21, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
130292	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	80464	3921||**1000003061||!||**1000015948	287792||583152	3921	E/N
102319	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	96850	3921||**1000003061||!||**1000015681	287792||583153	3921	E/N
140155	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	98510	3921||**1000003061||!||**1000060397	287792||583154	3921	E/N
140148	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	47997	3921||**1000003061||!||**1000060409	287792||583155	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00				287792||583156	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00				287792||583157	9347	N/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes
p/o # GIVEN BY FRANK HALL.

Enfinity Import Notes
ENTERED: Contract Number-287792

FREEDOM MEDICAL
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Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 285166.6.8

INVOICE DATE: 10/31/2013

DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 4/29/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option 3510071045	10/1/2013 Form: 190647	10/31/2013	44.00	995.00	31	995.00
1	0717091077	Puritan Bennett840 Graphicuser Interface 0717091077	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	0716001053	Puritan Bennett 802 Pbs Battery Pack 0716001053	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	3511070417	Puritan Bennett 806 Compressor 3511070417	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00
1	.AIR HOSE	Yellow Air Hose	10/1/2013 Form: 190647	10/31/2013	0.00	0.00	31	0.00

Comments:

deliver to 3rd floor respiratory please.

SUBTOTAL	995.00
TOTAL ORDER	995.00
TOTAL DUE	**995.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer
Carolyn Currenti (Signature)
Carolyn Currenti (Printed)

Freedom Rep
JAY (Signature)

Date and Time
4/29/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

4:55P TO 7:00P

$ 44.00 - day

$ 995.00 - monthly

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts) RC-190647

Contract # 284776
CustomerPO PENDING
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
5/3/2013 12:03:18 PM
Created by: tshappell@freedommedical.com
4/29/2013 4:47:19 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-560-6554

SalesRep Metro - Steve Vaccacio
Track Num

ShipMethod Driver Delivery
ShipCharge 0.00 **FuelCharge** 0.00

Start Date Monday, April 29, 2013
Delv Date Monday, April 29, 2013
Ship Date Monday, April 29, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
3510071045	Puritan Bennett 840 W/RM,PAV VV+ Option	44.00	0.00	995.00	0.00	1.00	PENDING	95870	3840||**1000002980||!||**1000013808	284776||571139	3840	N/Y
0717091077	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	95869	3833||**1000002973||!||**1000013040	284776||571140	3833	N/N
0716001053	Puritan Bennett 802 Pbs Battery Pack	0.00	0.00	0.00	0.00	1.00	PENDING	95871	4559||**1000003699||!||**1000023834	284776||571141	4559	N/N
3511070417	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	95989	4003||**1000003143||!||**1000016953	284776||571142	4003	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571143	9347	N/N
3510021663	Puritan Bennett 840 Ventilator	44.00	0.00	995.00	0.00	1.00	PENDING	114754	3834||**1000002974||!||**1000013199	284776||571144	3834	E/Y
02-170-91609	Puritan Bennett840 Graphicuser Interface	0.00	0.00	0.00	0.00	1.00	PENDING	114753	3833||**1000002973||!||**1000012923	284776||571145	3833	N/N
02-160-01655	Puritan Bennett 802 Power	0.00	0.00	0.00	0.00	1.00	PENDING	114752	4558||**1000003698||!||**1000023724	284776||571146	4558	N/N

	Backup Source											
3511020894	Puritan Bennett 806 Compressor	0.00	0.00	0.00	0.00	1.00	PENDING	17018	4003||**1000003143||!||**1000016942	284776||571147	4003	N/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571148	6168	N/N
.AIR HOSE	Yellow Air Hose	0.00	0.00	0.00	0.00	2.00	PENDING			284776||571149	6167	N/N

Comments **Patient Name:**
Room Number:
deliver to 3rd floor respiratory please.

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-284776

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 288613.6.9

INVOICE DATE: 10/31/2013

DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:	Ship To:
MR JIM VALERELLI-DIR OF CARDIO DNU-SOUND SHORE MEDICAL CENTER-MME SOUND SHORE MEDICAL CENTER 16 GUION PLACE NEW ROCHELLE, NY 10802	DNU-SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/24/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	113839	Respironics Bipap Vision	10/1/2013 Form: 193004	10/31/2013	9.00	200.00	31	200.00
2	.O2 HOSE	Green O2 Hose	10/1/2013 Form: 193004	10/31/2013	0.00	0.00	31	0.00
2	.BL-3020-R	Lamtic Round Handle Patient Arm	10/1/2013 Form: 193004	10/31/2013	0.00	0.00	31	0.00
1	130231	Respironics Bipap Vision 130231	10/1/2013 Form: 193004	10/31/2013	9.00	200.00	31	200.00

Comments:

SUBTOTAL	400.00
TOTAL ORDER	400.00
TOTAL DUE	**400.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

RC 193004 242

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC
193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Contact NENE

Street _____ City _____ State __ Zip _____ Phone 914-365-3910

Qty	Description	Serial / Part Number	Control Number
1	Bi PAP Vision	137873	98746
1	Hose green		
1	ARM		
1	Bi PAP Vision	130231	75535
1	Hose green		
1	ARM		

RESPIRATORY 3TH FLOOR

Comments

Customer

(Signature)

(Printed)

Freedom Medical Rep

Sandra LaVerde

(Signature)

Date and Time 5/24/13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surchages listed on invoices related to this delivery of equipment.

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-193004

Contract # 288613
CustomerPO nr176288
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:58 PM
Created by: ilaverde@freedommedical.com
5/28/2013 2:12:53 PM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nene
914-365-3910

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Friday, May 24, 2013
Delv Date Friday, May 24, 2013

Ship Date Tuesday, May 28, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CllvId	Price
107977	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	114707	3921||**1000003061||!||**1000015826	288613||586578	3921	E/N
113839	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	SO 6338	105587	3921||**1000003061||!||**1000069120	288613||586579	3921	E/N
.O2 HOSE	Green O2 Hose	0.00	0.00	0.00	0.00	4.00	SO 6338			288613||586580	6168	N/N
.BL-3020-R	Lamtic Round Handle Patient Arm	0.00	0.00	0.00	0.00	4.00	PENDING			288613||586581	9347	N/N
137873	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	98746	3921||**1000003061||!||**1000060455	288613||586582	3921	E/N
130231	Respironics Bipap Vision	9.00	63.00	200.00	0.00	1.00	PENDING	75535	3921||**1000003061||!||**1000015887	288613||586583	3921	E/N

Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-288613

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical (5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 289384.6.7

INVOICE DATE: 10/31/2013

DUE DATE: 11/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 5/16/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	13100320AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18040825AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	13030048AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.08	31	140.08
1	18040491AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.08	31	140.08
1	13090142AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	11110460AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	13100067AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	11020025AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18040471AD	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
1	18010392AL	Baxter I Pump Upgraded	10/1/2013 Form: 192111	10/31/2013	5.02	140.48	31	140.48
10	.15249A-MA	Cord, Bolus	10/1/2013 Form: 192111	10/31/2013	0.00	0.00	31	0.00
10		Keys	10/1/2013 Form: 192111	10/31/2013	0.00	0.00	31	0.00

Comments:

SUBTOTAL	1,404.00
TOTAL ORDER	1,404.00
TOTAL DUE	**1,404.00**

FREEDOM MEDICAL
CONSIDER IT DONE.™

Freedom Medical, Inc.
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE#	**289384.6.7**
INVOICE DATE:	10/31/2013
DUE DATE:	11/30/2013
ACCOUNT#	**4960**
ALTID#	126770

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Ticket | Pick Ticket | Packing Slip | Email Receipt | New WorkQueue | New Form

Metro

Rental Contract (Starts)

RC-192111

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverde@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)
4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013

Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y

.15249A-MA	Cord, Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N
	Keys	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589463	9741	N/N

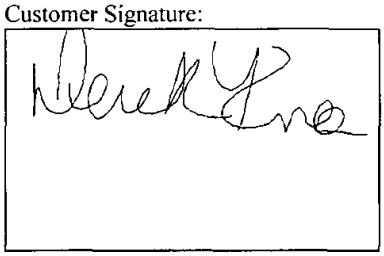
Comments **Patient Name:**
Room Number:

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

FREEDOM MEDICAL
CONSIDER IT DONE!™

Freedom Medical(5)
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE# 297681.5.6
INVOICE DATE: 11/30/2013
DUE DATE: 12/30/2013

ACCOUNT# 4960
ALTID# 126770

Bill To:

MR JIM VALERELLI-DIR OF CARDIO
DNU-SOUND SHORE MEDICAL CENTER-MME
SOUND SHORE MEDICAL CENTER
16 GUION PLACE
NEW ROCHELLE, NY 10802

Ship To:

DNU-SOUND SHORE MEDICAL CENTER-MME
16 GUION PLACE
NEW ROCHELLE, NY 10802

P.O. Number: nr176288
Salesperson: LI-Steve Vaccacio
Terms: Net 30

Ship date: 7/31/2013
Ship Via: Driver Delivery
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD BEGINNING	RENTAL BILLING PERIOD ENDING	Daily Rate	Monthly Rate	Days Billed	Amount
1	110308	Respironics Bipap Vision 110308	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	139276	Respironics Bipap Vision 139276	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	114915	Respironics Bipap Vision	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	107362	Respironics Bipap Vision 107362	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
1	142019	Respironics Bipap Vision	11/1/2013 Form: 198338	11/5/2013	9.00	200.00	5	45.00
5	.O2 HOSE	Green O2 Hose	11/1/2013 Form: 198338	11/5/2013	0.00	0.00	5	0.00
5	.BL-3020-R	Lamtic Round Handle Patient Arm	11/1/2013 Form: 198338	11/5/2013	0.00	0.00	5	0.00

Comments:

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

SUBTOTAL 225.00
TOTAL ORDER 225.00

TOTAL DUE 225.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-198338
Delv Date 7/31/2013
PO Number [redacted] NR176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Frank Hall
914-365-3910

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	110308	114024
1.00	Respironics Bipap Vision	139276	93007
1.00	Respironics Bipap Vision	114915	105240
1.00	Respironics Bipap Vision	107362	11133
1.00	Respironics Bipap Vision	142019	99132
5.00	Green O2 Hose	.O2 HOSE	
5.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor resp office
Also p/u 1 840 vent,and 2 broken bipap visions

Customer
SUNISH JACOB (Signature)
(Printed)

Freedom Rep (Signature)

Date and Time 7/31/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 306135.3.4

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30
Ship Date: 9/24/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	140193	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	107977	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	134918	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	139275	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
4	.02 HOSE	GREEN 02 HOSE						
4	.BI-3020-r	PATIENT ARM						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-202881

SUBTOTAL	$180.00
TOTAL DUE	**$180.00**

REMIT TO:

Freedom Medical Inc
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-202881
Delv Date 9/24/2013
PO Number ~~Pending~~ NR 176288

Customer 4960
Sound Shore Medical Center-MME
16 Guion Place
New Rochelle, NY 10802

Contact Angela Cortese
914-632-5000 ext 3913

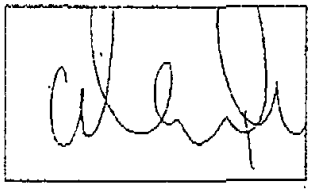
Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	140193	98744
1.00	Respironics Bipap Vision	107977	114707
1.00	Respironics Bipap Vision	134918	84801
1.00	Respironics Bipap Vision	139275	25716
4.00	Patient Arm Round Handle-lamtic	.BL-3020-R	
4.00	Hose, O2, (Green)	.O2 HOSE	

Comments **Patient Name:** **Room Number:**

Customer



Freedom Rep
Snyder Laverde

Date and Time
9/24/2013 11:34:41 AM

Full Name: elkin cardonna
Date Signed: 9/24/2013 11:34:41 AM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 285166.7.9

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: PENDING
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 4/29/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	3510071045	PB 840 W/RM,PAV VV+ OPTION	11/1/2013	11/5/2013	$44.00	$995.00	5	$220.00
1	717091077	PB 840 GRAPHICUSER INTERFACE						
1	716001053	PB 802 BATTERY PACK						
1	3511070417	PB 806 COMPRESSOR						
1	.BL-3020-R	PATIENT ARM						
1	.02 HOSE	GREEN O2 HOSE						
1	.AIR HOSE	YELLOW AIR HOSE						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-190647

SUBTOTAL	$220.00
TOTAL DUE	*$220.00*

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-190647
Delv Date 4/29/2013
PO Number PENDING

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
914-560-6554

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Puritan Bennett840 Graphicuser Interface	0717091077	95869
1.00	Puritan Bennett 802 Pbs Battery Pack	0716001053	95871
1.00	Puritan Bennett 806 Compressor	3511070417	95989
2.00	Patient Arm		
1.00	Puritan Bennett840 Graphicuser Interface	02-170-91609	114753
1.00	Puritan Bennett 802 Power Backup Source	02-160-01655	114752
1.00	Puritan Bennett 806 Compressor	3511020894	17018
2.00	Green O2 Hose	.O2 HOSE	
2.00	Yellow Air Hose	.AIR HOSE	

1 3510021663 S/N
1 3510071045 S/N

Comments **Patient Name:** **Room Number:**

deliver to 3rd floor respiratory please.

Customer Carolyn Currenti (Signature) (Printed)

Freedom Rep JAY (Signature)

Date and Time 4/29/13 __:__ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CarePfusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current Carefusion inventory.

4:55P TO 7:00P

$ 44.00-day

$ 995.00-monthly

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 287792.7.10

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/21/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	130292	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-192491

SUBTOTAL	$45.00
TOTAL DUE	**$45.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

Delivery Ticket

Ticket Number RC-192491
Delv Date 5/21/2013
PO Number ~~PENDING~~ NR176288

Customer 4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

Contact Nene
646-318-6811

Reason for Delivery New Rental

Ship Method Driver Delivery

Qty	Description	SerialNum	Control#
1.00	Respironics Bipap Vision	130292	80464
1.00	Respironics Bipap Vision	102319	96850
1.00	Respironics Bipap Vision	140155	98510
1.00	Respironics Bipap Vision	140148	47997
4.00	Green O2 Hose	.O2 HOSE	
4.00	Lamtic Round Handle Patient Arm	.BL-3020-R	

Comments **Patient Name:** **Room Number:**

3M

Customer (Signature)

Nene Kamel (Printed)

Freedom Rep Jay (Signature)

Date and Time 5/21/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment. The number of rented devices does not exceed 10% of the customer's current CareFusion inventory. The delivered device(s) software is the properly requested software compliant with the customer's current CareFusion inventory.

3:45 pm TO 6:00 P

FREEDOM MEDICAL

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 288613.7.10

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # 4960
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176288
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/24/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	113839	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
1	130231	RESPIRONICS BIPAP VISION	11/1/2013	11/5/2013	$9.00	$200.00	5	$45.00
2	.02 HOSE	GREEN 02 HOSE						
2	.BL-3020-R	PATIENT ARM						

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-193004

SUBTOTAL	$90.00
TOTAL DUE	$90.00

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

1-2

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC-193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date 5/24/13 Stop Date _____

PO Number NR176288 Reason _____

Customer Name SoundShore Medical Contact Nene

Street _____ City N. Rochelle, NY State _ Zip _____ Phone (914) 365-3910

Qty	Description	Serial / Part Number	Control Number
1	Bipap Vision	107977	114707
1	Bipap Vision	113834	105587
2	Ht arms		
2	O2 hoses.		

Comments

Customer _____ (Signature) _____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5/24/13 : AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

3:35 P.M.

RC-
193004

282

Freedom Medical, Inc. (05)
15-01 Pollitt Drive Unit4a
Fair Lawn, NJ 07410
Phone: (201)791-0900
Fax: (201)791-0988

RC
193004

Delivery/Pickup Ticket

○ Delivery ○ Pickup ○ Rent ○ Sale ○ Serivce

Delv Date _____ Stop Date _____

PO Number NR176288 Reason _____

Customer Name Sound Shore Contact Nene

Street _____ City _____ State __ Zip _____ Phone 914-365-3910

Qty	Description	Serial / Part Number	Control Number
①	Bi PAP Vision	1378173	98746
1	Hose Green		
1	ARM		
①	Bi PAP Vision	1302231	75535
1	Hose Green		
1	ARM		

Respiratory 3Th FLOOR

Comments

Customer _____ (Signature) _____ (Printed)

Freedom Medical Rep _____ (Signature)

Date and Time 5 7 13 : __ AM/PM

Customer agrees to pay all charges relating to the rental/sale of the above listed equipment as per the written proposal. Customer further agrees to pay for any damage to above listed equipment as a result of neglect or abuse caused by the customer. Any parts or accessories not returned with the equipment will be billed at the then current list price. Customer agrees to pay fuel surcharges listed on invoices related to this delivery of equipment.

Freedom Medical
219 Welsh Pool Road
Exton, PA 19341
800-784-8849
Fax: 610-903-0180
www.freedommedical.com

INVOICE

INVOICE 289384.7.8

INVOICE DATE: 11/30/2013

DUE DATE: 12/30/2013

ACCOUNT # **4960**
ALTID#

Bill To:	Ship To:
SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELL, NY 10802	SOUND SHORE MEDICAL CENTER-MME 16 GUION PLACE NEW ROCHELLE, NY 10802

P.O. Number: NR176990
Salesperson: LI-STEVE VACCACIO
Terms: NEET 30

Ship Date: 5/16/2013
Ship Via: DRIVER DELIVERY
Tracking #:

Qty	SERIAL/PART NUMBER	DESCRIPTION	RENTAL BILLING PERIOD		DAILY RATE	MONTHLY RATE	DAYS BILLED	AMOUNT
			BEGINNING	ENDING				
1	13100320AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040825AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13030048AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040491AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13090142AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	11110460AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	13100067AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	11020025AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18040471AD	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10
1	18010392AL	BAXTER I PUMP UPGRADED	11/1/2013	11/5/2013	$5.02	$140.48	5	$25.10

DELIVER TO 3RD FLOOR RESP OFFICE ON RC-192111

SUBTOTAL $251.00

TOTAL DUE **$251.00**

REMIT TO:

Freedom Medical, Inc.
PO Box 822704
Philadelphia, PA 19182-2704
Phone: 800-784-8849
Fax: 610-903-0180

Show Menu | Delivery Tick | Pick Ticket | Packing Slip | Email Receipt | New WorkQueu | New Form

Metro

Rental Contract (Starts) **RC-192111**

Contract # 289384
CustomerPO NR176990
Reason New Rental

Current Status: Reviewed

Changed by: czinn@freedommedical.com
6/5/2013 2:36:28 PM
Created by: ilaverde@freedommedical.com
5/16/2013 10:31:15 AM

Customer (4960)

4960
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10802

|| || Premier

Contact
Nick D'addesio
914-560-6554

SalesRep Metro - Steve Vaccacio

Track Num

ShipMethod Driver Delivery

ShipCharge 0.00 **FuelCharge** 0.00

Start Date Thursday, May 16, 2013
Delv Date Thursday, May 16, 2013

Ship Date Thursday, May 16, 2013

SerialNum	Description	Day	Week	Month	Sale	Qty	AI	CN	EnftIvItId	EnfTTnIvHdRntId	EnfT CIIvId	Price
13100320AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081807	289384||589452	6328	N/Y
18040825AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081808	289384||589453	6328	N/Y
13030048AL	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081809	289384||589454	6328	N/Y
18040491AD	Baxter I Pump Upgraded	5.02	0.00	140.08	0.00	1.00	NR176990		6328||**1000005468||!||**1000081805	289384||589455	6328	N/Y
13090142AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081806	289384||589456	6328	N/Y
11110460AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081810	289384||589457	6328	N/Y
13100067AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081811	289384||589458	6328	N/Y
11020025AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081812	289384||589459	6328	N/Y
18040471AD	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990		6328||**1000005468||!||**1000081804	289384||589460	6328	N/Y
18010392AL	Baxter I Pump Upgraded	5.02	0.00	140.48	0.00	1.00	NR176990	108785	6328||**1000005468||!||**1000080202	289384||589461	6328	N/Y
.15249A-MA	Cord, Bolus	0.00	0.00	0.00	0.00	10.00	NR176990			289384||589462	8406	N/N

	Keys	0.00	0.00	0.00	0.00	10.00	NR176990			289384	589463	9741	N/N

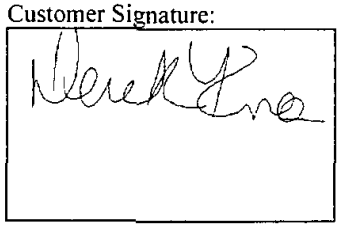
Comments **Patient Name:** **Room Number:**

Internal Notes

Billing Notes

Enfinity Import Notes
ENTERED: Contract Number-289384

Customer Signature:



Full Name: Dere Knoxville Knox
Date Signed: 5/16/2013 12:51:25 PM

Delivered By: Louis Alvarado
Delivery Date: 5/16/2013 12:51:29 PM

earthsmart
FedEx carbon-neutral envelope shipping

Align top of

ORIGIN ID NMZA (800) 784-8849
JEREMY CHESTER
FREEDOM MEDICAL INC
219 WELSH POOL RD

EXTON, PA 19341
UNITED STATES US

SHIP DATE 11DEC14
ACTWGT: 0.8 LB MAN
CAD: 628177/CAFE2806

BILL SENDER

TO C/O GCG INC.
SOUND SHORE MEDICAL OF WEST CHESTER
5151 BLAZER PARKWAY
SUITE A
DUBLIN OH 43017

REF: ART S

521C2/DC75/6F83

FedEx Express

J141214073801uv

FRI - 12 DEC 10:30A
PRIORITY OVERNIGHT

TRK# 0201 6122 1435 0358

XX OSUA

43017
OH-US LCK

Part # 156148-434 RIT2 06/14

RT 217 2 10:30 A 0358 12.12
ST 16

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)
Philip Heinegg, MD

☐ 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 14 2014

Name and Addresses Where Notices Should be Sent:
Philip Heinegg, MD
1890 Palmer Av
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): _____

2. DATE DEBT WAS INCURRED (IF KNOWN): JUNE - OCTOBER 2013

3. DESCRIPTION OF CLAIM (IF KNOWN). TEACHING MEDICAL STUDENTS & RESIDENTS

FILED - 01464
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 8000.00 (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: Philip Heinegg, MD
Title: _____
Company: _____
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: 914.315.1868

Philip Heinegg (Signature) 2/12/14 (Date)

email: heinegg6@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.

Philip C. Heinegg, M.D.
Board Certified Family Practice

Affiliated Physician
MDVIP
PERSONALIZED HEALTHCARE

SUMMARY OF MEDICAL STUDENT & RESIDENT TRAINING

ON BEHALF OF SOUND SHORE MEDICAL CENTER OF WESTCHESTER

06/30/13	16 HOURS
07/31/13	16 HOURS
08/31/13	16 HOURS
09/30/13	16 HOURS
10/31/13	16 HOURS

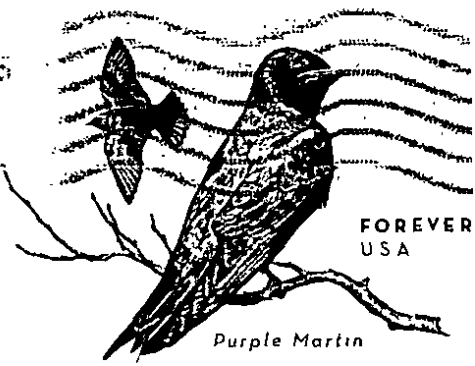
Total hours 80
Amount due $8000.00 (@$100.00/HR)

13-22840-rdd Doc 1139-7 Filed 12/15 Entered 06/29/15 15:01:16 Claims
Exhibit G Pg 3 of 19

Larchmont Family Medicine
Philip Heinegg, MD
Suraj Shah, MD
Shantann Savoy, MD
1898 Palmer Avenue Ste. 304
Larchmont, NY 10538

WESTCHESTER NY 365

12 FEB 2014 PM 5 L



Sound Shore Medical of Westchester, et al.

% GCG, Inc.

PO 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)
Temeca Jarvis

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:

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) Bonus & Severance Pay

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN):

FILED - 01350
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

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 acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

THIS SPACE IS FOR COURT USE ONLY

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: Temeca Jarvis
Title: Pharmacy Technician
Company: Sound Shore Medical Center
Address and telephone number (if different from notice address above):
4127 Wickham Ave
Bronx NY 10466
Telephone number: 917-755-2146

(Signature) 1/30/14 (Date)

email: Temeca.Jarvis@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

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

4301755282

Bronx, NY 10466
827 Wickham Ave
Brenda Jarvis

6187058

FILED - 01499
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	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)
JC Ehrlich Pest Control

☐ 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. JUN 16 2014

Name and Addresses Where Notices Should be Sent:
JC Ehrlich Pest Control
PO Box 13848
Reading PA 19610

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: 6187058

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): 10/2/13

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 292.62 (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: LINDA HALL
Title: _____
Company: JC Ehrlich Pest Control
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: 610 372 9700

Linda Hall (Signature) 6-12-14 (Date)

email: LINDA.Hall@Rentokil.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.

13-22840-rdd Doc 1139-7 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Part 5 Pg 7 of 19

Rentokil

Ehrlich | Western | Presto-X

Your Local Pest Control Experts

125 Berkshire Blvd.
Suite 150
Reading, PA 19610-1211

Address Service Requested

Hasler
06/13/2014
US POSTAGE

FIRST-CLASS MAIL
$00.48⁰

ZIP 19610
011D12602161

Sound Shore Medical of Westchester
GHG INC
PO Box 9982
Dublin OH 43017

4301735582

FILED - DRAIN
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	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	☐ NRJHMC 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)
LexisNexis

☐ 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. JUN 18 2014

Name and Addresses Where Notices Should be Sent
LexisNexis
9443 Springboro Pike
Miamisburg, OH 45342
937-247-4503

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: 118BHW

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): 8/1/2013 - 3/31/2014

3. DESCRIPTION OF CLAIM (IF KNOWN).

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 3,873.62 (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 Robert Berry
Title: Manager Customer Accounting
Company: LexisNexis
Address and telephone number (if different from notice address above).
937-247-3120

Robert Berry (Signature) 4/9/14 (Date)

Telephone number: _____ 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

CRT

LeeAnne Gammie
9443 Springboro Pike
Miamisburg, OH 45342
4/9/2014

US Bankruptcy Court SDNY
Attention: Clerk of Courts
300 Quarropas St. Room 248
White Plains, NY 10601

To Whom It May Concern:

I am submitting this Proof of Claim for services rendered by LexisNexis, A Division of Reed Elsevier to Sound Shore Medical Center of Westchester et al (118BHW). This claim is in reference to case number 13-22840-(RDD).

LexisNexis, A Division of Reed Elsevier provides computer-assisted legal, tax, regulatory and news & business information and analysis to legal, corporate, government, accounting and academic markets.

Included are the following documents substantiating the claim:

1. Proof of Claim.
2. Customer Account Summary totaling amount due.
3. Outstanding Invoices for the period 8/1/2013-3/31/2014.

Please feel free to call me with any questions, and please acknowledge your receipt of this claim to leeanne.gammie@lexisnexis.com, or the address at the top of this letter.

Sincerely

LeeAnne Gamme
Customer Accounting Specialist
(937) 247-1503
leeanne.gammie@lexisnexis.com

LexisNexis

INVOICE #	DATE	ACCOUNT NUMBER
130810339R	4/8/2014	118BHW

BILLING PERIOD: 8/1/2013-3/31/2014

US Federal Tax ID: 52-1471842
Canadian GST Registration Number: 123397457RT
Dun and Bradstreet Number: 87-767-2683

TO:
ATTENTION: SOUND SHORE MEDICAL

FOR INQUIRIES REGARDING THIS ACCOUNT CONTACT YOUR ACCOUNT REPRESENTATIVE. FOR THE NAME AND NUMBER OF YOUR REPRESENTATIVE CALL 800-543-6862.

SUMMARY		
DESCRIPTION		**TOTAL AMOUNT**
LEXISNEXIS ONLINE & RELATED CHARGES FOR:		
INVOICE	1308103399	$650.96
INVOICE	1311102867	$670.48
INVOICE	1312102751	$670.48
INVOICE	1401102346	$670.48
INVOICE	1402102219	$670.48
INVOICE	1403101842	$540.74
TOTAL	**CURRENCY:** US DOLLARS	**$3,873.62**

REMIT TO:
LEXISNEXIS
ATTN: LEEANNE GAMMIE
9443 SPRINGBORO PIKE
MIAMISBURG OH 45342

LexisNexis

PREPARED BY: LeeAnne Gammie
937-247-1503
leeanne.gammie@lexisnexis.com

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1308103399	31-AUG-13	118BHW

BILLING PERIOD 01-AUG-13 - 31-AUG-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1.

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 650.96
CURRENT PERIOD TOTAL	**$ 650.96**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1308103399	31-AUG-13	118BHW

BILLING PERIOD 01-AUG-13 - 31-AUG-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 650.96

PAYMENT TERMS: NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220130831130810339900000000650965

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1311102867	30-NOV-13	118BHW

BILLING PERIOD 01-NOV-13 - 30-NOV-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

***FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1 ***

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 670.48
CURRENT PERIOD TOTAL	**$ 670.48**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1311102867	30-NOV-13	118BHW

BILLING PERIOD 01-NOV-13 - 30-NOV-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 670.48

PAYMENT TERMS. NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220131130131110286700000000670481

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1312102751	31-DEC-13	118BHW

BILLING PERIOD 01-DEC-13 - 31-DEC-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1.

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 670 48
CURRENT PERIOD TOTAL	**$ 670.48**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1312102751	31-DEC-13	118BHW

BILLING PERIOD 01-DEC-13 - 31-DEC-13

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 670.48

PAYMENT TERMS: NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220131231131210275100000000670481

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1401102346	31-JAN-14	118BHW

BILLING PERIOD 01-JAN-14 - 31-JAN-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1.

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 670.48
CURRENT PERIOD TOTAL	**$ 670.48**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1401102346	31-JAN-14	118BHW

BILLING PERIOD 01-JAN-14 - 31-JAN-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 670.48

PAYMENT TERMS: NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220140131140110234600000000670482

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1402102219	28-FEB-14	118BHW

BILLING PERIOD 01-FEB-14 - 28-FEB-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1.

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 670.48
CURRENT PERIOD TOTAL	**$ 670.48**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1402102219	28-FEB-14	118BHW

BILLING PERIOD 01-FEB-14 - 28-FEB-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 670.48

PAYMENT TERMS: NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220140228140210221900000000670483

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1403101842	31-MAR-14	118BHW

BILLING PERIOD 01-MAR-14 - 31-MAR-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

INVOICE TO:
ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

FOR INQUIRIES REGARDING THIS INVOICE PLEASE CALL 888-856-7881 AND PRESS 1.

INVOICE SUMMARY

DESCRIPTION	TOTAL AMOUNT
CURRENT PERIOD CHARGES	
LEXISNEXIS & RELATED CHARGES	$ 540.74
CURRENT PERIOD TOTAL	**$ 540.74**

LexisNexis

INVOICE NO.	INVOICE DATE	ACCOUNT NUMBER
1403101842	31-MAR-14	118BHW

BILLING PERIOD 01-MAR-14 - 31-MAR-14

US FEDERAL TAX ID 52-1471842
CANADIAN GST REGISTRATION NUMBER 123397457RT
DUN AND BRADSTREET NUMBER 87-767-2683

REMIT TO: LEXISNEXIS
PO BOX 7247-7090
PHILADELPHIA, PA 19170-7090

AMOUNT DUE IN:	
US DOLLAR	$ 540.74

PAYMENT TERMS: NET 10 DAYS FROM RECEIPT

INVOICE TO:

ATTENTION: CLARK E WALTER
SOUND SHORE MEDICAL
16 GUION PL
NEW ROCHELLE NY 10801-5500
UNITED STATES

AMOUNTS WHICH HAVE NOT BEEN PAID WITHIN 30 DAYS AFTER THE INVOICE DATE WILL THEREAFTER, UNTIL PAID, BE SUBJECT TO A LATE PAYMENT CHARGE AT A RATE EQUAL TO 15.000% PER ANNUM (OR, IF LESS, THE MAXIMUM RATE PERMITTED UNDER APPLICABLE LAW).

118BHW220140331140310184200000000540744

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

ROUTING SHEET FOR CASES WITH CLAIMS AGENTS

Date: June 17, 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: 6

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

Herbert Cornell	$4,000.00
Lexis Nexis	$3,873.62
Empire Healthchoice Assurance	(See Attachment)
Empire Healthchoice Assurance	(See Attachment)
State of NY Dept of Labor	$129,008.79
State of NY Dept of Labor	$310,798.20

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: _____

If Borrower is not a natural Person and a beneficial interest in Borrower is sold or transferred without Lender's prior written permission, Lender also may require Immediate Payment in Full. However, this option shall not be exercised by Lender if such exercise is prohibited by Applicable Law.

If Lender requires Immediate Payment in Full under this Section 18, Lender will give me a notice which states this requirement. The notice will give me at least 30 days to make the required payment. The 30-day period will begin on the date the notice is given to me in the manner required by Section 15 of this Security Instrument. If I do not make the required payment during that period, Lender may act to enforce its rights under this Security Instrument without giving me any further notice or demand for payment.

19. Borrower's Right to Have Lender's Enforcement of this Security Instrument Discontinued. Even if Lender has required Immediate Payment in Full, I may have the right to have enforcement of this Security Instrument stopped. I will have this right at any time before the earliest of: (a) five days before sale of the Property under any power of sale granted by this Security Instrument; (b) another period as Applicable Law might specify for the termination of my right to have enforcement of the Loan stopped; or (c) a judgment has been entered enforcing this Security Instrument. In order to have this right, I will meet the following conditions:

(a) I pay to Lender the full amount that then would be due under this Security Instrument and the Note as if Immediate Payment in Full had never been required;

(b) I correct my failure to keep any of my other promises or agreements made in this Security Instrument;

(c) I pay all of Lender's reasonable expenses in enforcing this Security Instrument including, for example, reasonable attorneys' fees, property inspection and valuation fees, and other fees incurred for the purpose of protecting Lender's interest in the Property and rights under this Security Instrument; and

(d) I do whatever Lender reasonably requires to assure that Lender's interest in the Property and rights under this Security Instrument and my obligations under the Note and under this Security Instrument continue unchanged.

Lender may require that I pay the sums and expenses mentioned in (a) through (d) in one or more of the following forms, as selected by Lender: (a) cash; (b) money order; (c) certified check, bank check, treasurer's check or cashier's check drawn upon an institution whose deposits are insured by a federal agency, instrumentality or entity; or (d) Electronic Funds Transfer.

If I fulfill all of the conditions in this Section 19, then this Security Instrument will remain in full effect as if Immediate Payment in Full had never been required. However, I will not have the right to have Lender's enforcement of this Security Instrument discontinued if Lender has required Immediate Payment in Full under Section 18 of this Security Instrument.

20. Note Holder's Right to Sell the Note or an Interest in the Note; Borrower's Right to Notice of Change of Loan Servicer; Lender's and Borrower's Right to Notice of Grievance. The Note, or an interest in the Note, together with this Security Instrument, may be sold one or more times. I might not receive any prior notice of these sales.

The entity that collects the Periodic Payments and performs other mortgage loan servicing obligations under the Note, this Security Instrument, and Applicable Law is called the "Loan Servicer." There may be a change of the Loan Servicer as a result of the sale of the Note. There also may be one or more changes of the Loan Servicer unrelated to a sale of the Note. Applicable Law requires that I be given written notice of any change of the Loan Servicer. The notice will state the name and address of the new Loan Servicer, and also tell me the address to which I should make my payments. The notice also will contain any other information required by RESPA or Applicable Law. If the Note is sold and thereafter the Loan is serviced by a Loan Servicer other than the purchaser of the Note, the mortgage loan servicing obligations to me will remain with the Loan Servicer or be transferred to a successor Loan Servicer and are not assumed by the Note purchaser unless otherwise provided by the Note purchaser.

Neither I nor Lender may commence, join or be joined to any court action (as either an individual party or the member of a class) that arises from the other party's actions pursuant to this Security Instrument or that alleges that the other has not fulfilled any of its obligations under this Security Instrument, unless the other is notified (in the manner required under Section 15 of this Security Instrument) of the unfulfilled obligation and given a reasonable time period to take corrective action. If Applicable Law provides a time period which

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 6578
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.

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 $500, 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.

FILED - 0175

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	**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)
Linde North Gas

☐ 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. MAR 20 2014

Name and Addresses Where Notices Should be Sent:
Linde
Attn: Christian Hobbis
Senior Credit Analyst
575 Mountain Ave
Murray Hill NJ 07974
(908) 464-8458 Christian.Hobbis@Linde.com

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:
2477868 - 2540167

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): 5/30/13 - 11/1/13

3. DESCRIPTION OF CLAIM (IF KNOWN):
Administrative Expense - Goods Sold Excludable Xlegect
Acct# 2477868 = $37,821.31
Acct# 2540167 = $ 7,413.11

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $45,234.42 (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):
_____
_____
_____
Telephone number: _____

_____ (Signature) 3/17/14 (Date)

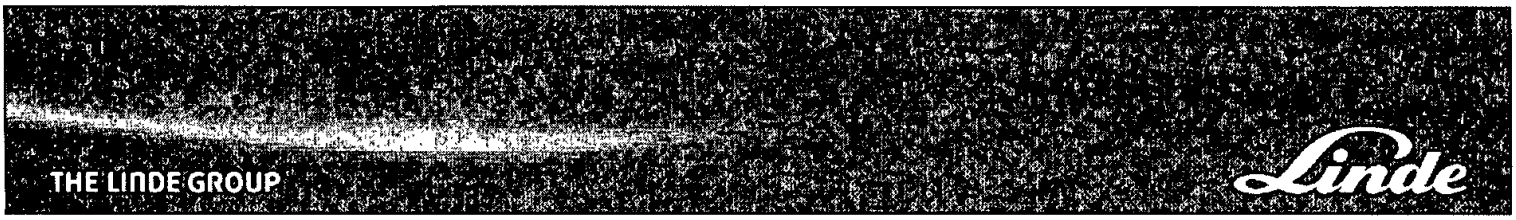
email: _____

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.



Sound Shore Medical Center of Westchester, et al.,
C/O GCG, Inc., P.O. Box 9982
Dublin, Ohio
Bankruptcy Case # 13-22843

Linde/ LifeGas
Christian Hobbis-Senior Credit Analyst
575 Mountain Ave
Murray Hill, NJ 07974

To whom it may concern,

Linde/Lifegas failed to file a timely Administrative Expense Proof of Claim for case # 13-22843 due to excusable neglect. I am a new employee to Linde/LifeGas and during may initial training I was informed that all bankruptcy cases where the total debts owed to Linde/LifeGas equal to $100,000 or greater are handled by a specific individual within the company. Working under this assumption, when the Administrative Expense claim was received from the court, I took no action. Recently one of our collectors was told that we weren't going to be paid for the goods sold between 5/29/13 and 11/6/13 because we failed to file a claim.

When the collector shared this information with me I immediately located the bankruptcy file and found that that previous Credit Analyst did not follow proper procedure and filed the initial Proof of Claim himself. (The bankruptcy case should have been referred to the individual who handles all cases where the total debts owed to Linde/LifeGas are equal to $100,000 or greater.

This mistake on my part was not an intentional inadvertence to file a timely Administrative Expense Proof of Claim. The customer is this case was required by court to pay their post bankruptcy debts according to their terms of this account, and they did not meet their obligation. As careless as my mistake was, it was not intentional and I apologize for the breakdown in our internal procedures.

I respectfully request that you take the reasons listed above into consideration and ensure that the client pays Linde/LifeGas for the debts it incurred for good sold between 5/29/13 and 11/6/13

Thank you for your time and consideration

Sincerely

Christian Hobbis
Senior Credit Analyst
Linde/LifeGas

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	06/01/2013
Invoice Number	47708803
Payment Due By	06/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to	PO	Release	SH
Customer No: 2476443	Number: MV21911	Number:	CODE

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283						
MED OXY LIQ REC - 4501-6075G			1	EA	1,661.46	1,661.46
MV21911						
26001284						
MED OXY LIQ REC - 6076-9300G			1	EA	0.00	0.00
MV21911						

MONTHLY CHARGES for June

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

Account #
2477868
$37,821.31

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTIONS 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED AND OF REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF

LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AR130601.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	09/11/2013
Invoice Number	48333313
Payment Due By	09/21/2013
Terms	Net 10 days
Invoice Total	$2,095.45

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	09/11/2013	558592987	188,879	CCF	0.93	1,756.57
COMPLIANCE CHARGE	09/11/2013	558592987	1	EA	25.00	25.00
CERT OF ANALYS TRL	09/11/2013	558592987	1	EA	125.00	125.00
FUEL SURCHARGE	09/11/2013	558592987	1	EA	0.055	103.88
ENERGY SURCHARGE	09/11/2013	558592987	1	EA	0.045	85.00

SUBTOTAL	2,095.45
TOTAL TAX	0.00
INVOICE TOTAL	$2,095.45

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS, CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AI130913.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	06/21/2013
Invoice Number	47818568
Payment Due By	07/03/2013
Terms	Net 10 days
Invoice Total	$3,130.42

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO** Number: MV21911 **Release** Number: **SH** CODE 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	06/21/2013	558328152	289,361	CCF	0.93	2,691.06
COMPLIANCE CHARGE	06/21/2013	558328152	1	EA	25.00	25.00
CERT PROD ANALYS	06/21/2013	558328152	1	EA	125.00	125.00
FUEL SURCHARGE	06/21/2013	558328152	1	EA	0.055	159.15
ENERGY SURCHARGE	06/21/2013	558328152	1	EA	0.045	130.21

SUBTOTAL	3,130.42
TOTAL TAX	0.00
INVOICE TOTAL	$3,130.42

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING, AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1130624 dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	09/17/2013
Invoice Number	48361400
Payment Due By	09/27/2013
Terms	Net 10 days
Invoice Total	$3,804.98

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 | **PO** Number: MV21911 | **Release** Number: | **SH** CODE 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	09/17/2013	558612760	354,853	CCF	0.93	3,300.13
COMPLIANCE CHARGE	09/17/2013	558612760	1	EA	25.00	25.00
CERT OF ANALYS TRL	09/17/2013	558612760	1	EA	125.00	125.00
FUEL SURCHARGE	09/17/2013	558612760	1	EA	0.055	195.17
ENERGY SURCHARGE	09/17/2013	558612760	1	EA	0.045	159.68

SUBTOTAL	3,804.98
TOTAL TAX	0.00
INVOICE TOTAL	$3,804.98

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1130915.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	07/01/2013
Invoice Number	47892790
Payment Due By	07/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to	PO	Release	SH
Customer No: 2476443	Number: MV21911	Number:	CODE

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283						
MED OXY LIQ REC - 4501-6075G			1	EA	1,661.46	1,661.46
MV21911						
26001284						
MED OXY LIQ REC - 6076-9300G			1	EA	0.00	0.00
MV21911						

MONTHLY CHARGES for July

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AF130701.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	10/01/2013
Invoice Number	48459934
Payment Due By	10/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to	PO	Release	SH
Customer No: 2476443	**Number:** MV21911	**Number:**	**CODE**

Material No. Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283 MED OXY LIQ REC - 4501-6075G MV21911			1	EA	1,661.46	1,661.46
26001284 MED OXY LIQ REC - 6076-9300G MV21911			1	EA	0.00	0.00

MONTHLY CHARGES for October

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AF131001 dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	07/09/2013
Invoice Number	47944659
Payment Due By	07/21/2013
Terms	Net 10 days
Invoice Total	$1,987.57

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	07/09/2013	558381011	178,405	CCF	0.93	1,659.17
COMPLIANCE CHARGE	07/09/2013	558381011	1	EA	25.00	25.00
CERT PROD ANALYS	07/09/2013	558381011	1	EA	125.00	125.00
FUEL SURCHARGE	07/09/2013	558381011	1	EA	0.055	98.12
ENERGY SURCHARGE	07/09/2013	558381011	1	EA	0.045	80.28

SUBTOTAL	1,987.57
TOTAL TAX	0.00
INVOICE TOTAL	$1,987.57

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AI130711.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	09/29/2013
Invoice Number	48464341
Payment Due By	10/09/2013
Terms	Net 10 days
Invoice Total	$3,522.84

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	09/29/2013	558654205	327,460	CCF	0.93	3,045.38
COMPLIANCE CHARGE	09/29/2013	558654205	1	EA	25.00	25.00
CERT OF ANALYS TRL	09/29/2013	558654205	1	EA	125.00	125.00
FUEL SURCHARGE	09/29/2013	558654205	1	EA	0.055	180.10
ENERGY SURCHARGE	09/29/2013	558654205	1	EA	0.045	147.36

SUBTOTAL	3,522.84
TOTAL TAX	0.00
INVOICE TOTAL	$3,522.84

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1131001.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	07/11/2013
Invoice Number	47958880
Payment Due By	07/23/2013
Terms	Net 10 days
Invoice Total	$3,944.89

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	07/11/2013	558389294	368,435	CCF	0.93	3,426.45
COMPLIANCE CHARGE	07/11/2013	558389294	1	EA	25.00	25.00
CERT PROD ANALYS	07/11/2013	558389294	1	EA	125.00	125.00
FUEL SURCHARGE	07/11/2013	558389294	1	EA	0.055	202.64
ENERGY SURCHARGE	07/11/2013	558389294	1	EA	0.045	165.80

SUBTOTAL	3,944.89
TOTAL TAX	0.00
INVOICE TOTAL	$3,944.89

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING, AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1130715.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

SERVICE INVOICE

Customer Number	2477868
Invoice Date	10/14/2013
Invoice Number	48530082
Payment Due By	10/24/2013
Terms	Net 10 days
Invoice Total	$650.25

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

34025528

Ship to Customer No: 2476443	PO Number:	Release Number: 34025528	SH CODE 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
14002757						
SAFETY INSPECTION	10/14/2013	15477513	1	EA	765.00	765.00
CES MULTITANK DISC	10/14/2013	15477513	1	EA	-150.00	-114.75
Work Order# 34025528 - 6000 Gallon Oxygen Tank #600-1166, Annual Inspection, 10/8/13						

SUBTOTAL	650.25
TOTAL TAX	0.00
INVOICE TOTAL	$650.25

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AI131015 dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	07/25/2013
Invoice Number	48029670
Payment Due By	08/08/2013
Terms	Net 10 days
Invoice Total	$1,168.37

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	07/25/2013	558433224	98,871	CCF	0.93	919.50
COMPLIANCE CHARGE	07/25/2013	558433224	1	EA	25.00	25.00
CERT PROD ANALYS	07/25/2013	558433224	1	EA	125.00	125.00
FUEL SURCHARGE	07/25/2013	558433224	1	EA	0.055	54.38
ENERGY SURCHARGE	07/25/2013	558433224	1	EA	0.045	44.49

SUBTOTAL	1,168.37
TOTAL TAX	0.00
INVOICE TOTAL	$1,168.37

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS, CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1130730 dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	10/17/2013
Invoice Number	48556456
Payment Due By	10/27/2013
Terms	Net 10 days
Invoice Total	$2,308.85

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443	PO Number: MV21911		Release Number:			SH CODE 19
Material No: Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	10/17/2013	558715727	209,597	CCF	0.93	1,949.25
COMPLIANCE CHARGE	10/17/2013	558715727	1	EA	25.00	25.00
CERT OF ANALYS TRL	10/17/2013	558715727	1	EA	125.00	125.00
FUEL SURCHARGE	10/17/2013	558715727	1	EA	0.055	115.28
ENERGY SURCHARGE	10/17/2013	558715727	1	EA	0.045	94.32

SUBTOTAL	2,308.85
TOTAL TAX	0.00
INVOICE TOTAL	$2,308.85

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING, AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTIONS 6,7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED AND OF REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF

LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AI131021.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	08/01/2013
Invoice Number	48082970
Payment Due By	08/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443	PO Number: MV21911	Release Number:	SH CODE

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283						
MED OXY LIQ REC - 4501-6075G			1	EA	1,661.46	1,661.46
MV21911						
26001284						
MED OXY LIQ REC - 6076-9300G			1	EA	0.00	0.00
MV21911						

MONTHLY CHARGES for August

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS, CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

WE HEREBY CERTIFY THAT THESE GOODS WERE PRODUCED IN COMPLIANCE WITH ALL APPLICABLE REQUIREMENTS OF SECTIONS 6 7 AND 12 OF THE FAIR LABOR STANDARDS ACT, AS AMENDED AND OF REGULATIONS AND ORDERS OF THE UNITED STATES DEPARTMENT OF LABOR ISSUED UNDER SECTION 14 THEREOF

LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AF130801.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	11/01/2013
Invoice Number	48660196
Payment Due By	11/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443	PO Number: MV21911	Release Number:	SH CODE

Material No: Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283						
MED OXY LIQ REC - 4501-6075G			1	EA	1,661.46	1,661.46
MV21911						
26001284						
MED OXY LIQ REC - 6076-9300G			1	EA	0.00	0.00
MV21911						

MONTHLY CHARGES for November

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AF131101.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	08/03/2013
Invoice Number	48102265
Payment Due By	08/15/2013
Terms	Net 10 days
Invoice Total	$3,790.76

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443 **PO Number:** MV21911 **Release Number:** **SH CODE** 19

Material No: / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	08/03/2013	558463645	353,472	CCF	0.93	3,287.29
COMPLIANCE CHARGE	08/03/2013	558463645	1	EA	25.00	25.00
CERT PROD ANALYS	08/03/2013	558463645	1	EA	125.00	125.00
FUEL SURCHARGE	08/03/2013	558463645	1	EA	0.055	194.41
ENERGY SURCHARGE	08/03/2013	558463645	1	EA	0.045	159.06

SUBTOTAL	3,790.76
TOTAL TAX	0.00
INVOICE TOTAL	$3,790.76

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING, AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

A1130805.dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	09/01/2013
Invoice Number	48272121
Payment Due By	09/11/2013
Terms	Net 10 days
Invoice Total	$1,661.46

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to Customer No: 2476443	PO Number: MV21911	Release Number:	SH CODE

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
26001283						
MED OXY LIQ REC - 4501-6075G			1	EA	1,661.46	1,661.46
MV21911						
26001284						
MED OXY LIQ REC - 6076-9300G			1	EA	0.00	0.00
MV21911						

MONTHLY CHARGES for September

SUBTOTAL	1,661.46
TOTAL TAX	0.00
INVOICE TOTAL	$1,661.46

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AP130901 dat

LifeGas

Linde Gas North America LLC
575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2477868
Invoice Date	08/29/2013
Invoice Number	48276689
Payment Due By	09/10/2013
Terms	Net 10 days
Invoice Total	$1,448.17

ATTN: MVH ENGINEERING DEPT
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MOUNT VERNON HOSPITAL INC
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

PLEASE MAKE CHECK PAYABLE AND MAIL TO:
LINDE GAS NORTH AMERICA LLC
88222 EXPEDITE WAY
CHICAGO IL 60695

Ship to **Customer No:** 2476443 | **PO Number:** MV21911 | **Release Number:** | **SH CODE** 19

Material No. / Material Description	Date Shipped	Delivery Number	Quantity	UoM	Unit Price	Amount
25001114						
BULK LIQUID MEDICAL OXYGEN	08/29/2013	558549166	126,035	CCF	0.93	1,172.13
COMPLIANCE CHARGE	08/29/2013	558549166	1	EA	25.00	25.00
CERT OF ANALYS TRL	08/29/2013	558549166	1	EA	125.00	125.00
FUEL SURCHARGE	08/29/2013	558549166	1	EA	0.055	69.32
ENERGY SURCHARGE	08/29/2013	558549166	1	EA	0.045	56.72

SUBTOTAL	1,448.17
TOTAL TAX	0.00
INVOICE TOTAL	$1,448.17

INVOICE INQUIRIES: 1-800-348-3349 EXT: X2464

THE TOTAL AMOUNT DUE FROM THE CUSTOMER MAY INCLUDE VARIOUS ITEMIZED CHARGES, INCLUDING: CHARGES FOR THE HANDLING OF HAZARDOUS MATERIALS AND FOR COMPLIANCE WITH LAWS AND REGULATIONS CONCERNING HAZARDOUS MATERIALS; CHARGES FOR HANDLING, DELIVERY, AND SHIPPING; AND/OR CHARGES FOR ENERGY OR FUEL. NONE OF THE CHARGES REPRESENT A TAX OR FEE PAID TO OR IMPOSED BY ANY GOVERNMENTAL AUTHORITY, AND ALL OF THE CHARGES ARE RETAINED BY THE COMPANY.

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LATE PAYMENT MAY BE SUBJECT TO FINANCE CHARGE

AI130902.dat

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	05/30/2013
Invoice Number	47694053
Payment Due By	06/29/2013
Terms	Net 30 days
Invoice Total	$1,105.78

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 05/30/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	6183.00	0.158	976.91
OXYGEN USP OXY-GEN-1 ALUM DISS E	99.00	0.158	15.64
OXYGEN USP LIV E	660.00	0.158	104.28

Account #
2540167
7,413.11

Compliance Charge	8.95
Subtotal Amount	1105.78
Tax	0.00
Total	1105.78

FOR INQUIRIES CALL: 1-866-543-3427

This invoice is subject to Terms and Conditions below

We may charge to you a regulatory compliance cost charge ("Compliance Charge") The Compliance Charge results from the costs incurred by us in order to comply with federal, state, and local laws However, those costs are difficult to calculate and apportion with precision. Therefore, the amount of the Compliance Charge is not related to actual compliance costs incurred by us, which may vary by the type of Product, service, geographic location, or time The Compliance Charge is not a federal, state, or local tax, and we need not collect and pay the Compliance Charge to any federal, state, or local government You shall pay all of our invoices within 30 days after the invoice date. Starting on the invoice date, we may charge interest on past due invoices at the lower of (1) 1½% per month, or (2) the highest rate permitted by law Due to the high cost of cylinders, it is important that you check your cylinder balances as shown above to see if they agree with your records Call us immediately if there are any discrepancies If we do not hear from you within 10 days of this invoice date, then we will consider your physical cylinder balances to agree with our records, and our records are binding. We will bill you for "loss of use" at current value for cylinders not returned or damaged. Save your returned cylinder receipts If you and us have a signed contract and the terms of the signed contract conflict with these terms, then the terms of the signed contract govern.

PAYMENT SLIP

Please do not fold or staple

Invoice Number	47694053
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$1,105.78
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX130531.dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 6) Pg 21 of 35

INVOICE NO 47694053

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895 MT VERNON HOSPITAL 12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167 Mt VERNON HOSPITAL 16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		3	0	0	0	3
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		183	48	40	0	191
	OXYGEN MEDICYL-E-LITE	183	48	40	0	191
RENT OXY MED LIV 3000 SM		20	0	0	0	20
	OXYGEN USP LIV E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned
26001575	RENT MEDICYL-E-LITE				
109855	OXYGEN MEDICYL-E-LITE				
		05/13/2013	219663742	48	40

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	06/27/2013
Invoice Number	47876495
Payment Due By	07/27/2013
Terms	Net 30 days
Invoice Total	$955.68

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 06/27/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	5348.00	0.158	844.98
OXYGEN USP OXY-GEN-1 ALUM DISS E	84.00	0.158	13.27
OXYGEN USP LIV E	560.00	0.158	88.48

Compliance Charge	8.95
Subtotal Amount	955.68
Tax	0.00
Total	955.68

FOR INQUIRIES CALL: 1-866-543-3427

This invoice is subject to Terms and Conditions below

We may charge to you a regulatory compliance cost charge ("Compliance Charge") The Compliance Charge results from the costs incurred by us in order to comply with federal, state, and local laws. However, those costs are difficult to calculate and apportion with precision. Therefore, the amount of the Compliance Charge is not related to actual compliance costs incurred by us, which may vary by the type of Product, service, geographic location, or time. The Compliance Charge is not a federal, state, or local tax, and we need not collect and pay the Compliance Charge to any federal, state, or local government You shall pay all of our invoices within 30 days after the invoice date Starting on the invoice date, we may charge interest on past due invoices at the lower of (1) 1½% per month, or (2) the highest rate permitted by law Due to the high cost of cylinders, it is important that you check your cylinder balances as shown above to see if they agree with your records. Call us immediately if there are any discrepancies. If we do not hear from you within 10 days of this invoice date, then we will consider your physical cylinder balances to agree with our records, and our records are binding We will bill you for "loss of use" at current value for cylinders not returned or damaged Save your returned cylinder receipts. If you and us have a signed contract and the terms of the signed contract conflict with these terms, then the terms of the signed contract govern.

PAYMENT SLIP

Please do not fold or staple

Invoice Number	47876495
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$955.68
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail

Detach this payment slip and mail with payment

By Credit Card

Payment can be made by calling 1-800-348-3349

By ACH

ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX130628 dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Pg 23 of 35
(Part 6)

INVOICE NO 47876495

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895	MT VERNON HOSPITAL	12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167	Mt VERNON HOSPITAL	16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		3	0	0	0	3
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		191	0	0	0	191
	OXYGEN MEDICYL-E-LITE	191	0	0	0	191
RENT OXY MED LIV 3000 SM		20	0	0	0	20
	OXYGEN USP LIV E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	07/30/2013
Invoice Number	48068138
Payment Due By	08/29/2013
Terms	Net 30 days
Invoice Total	$1,124.74

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 07/30/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	6303.00	0.158	995.87
OXYGEN USP OXY-GEN-1 ALUM DISS E	99.00	0.158	15.64
OXYGEN USP LIV 3000 E	660.00	0.158	104.28

Compliance Charge	8.95
Subtotal Amount	1124.74
Tax	0.00
Total	1124.74

FOR INQUIRIES CALL: 1-866-543-3427

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PAYMENT SLIP

Please do not fold or staple

Invoice Number	48068138
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$1,124.74
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX130731.dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Pg 25 of 35
(Part 6)

INVOICE NO 48068138

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895	MT VERNON HOSPITAL	12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167	Mt VERNON HOSPITAL	16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		3	0	0	0	3
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		191	0	0	0	191
	OXYGEN MEDICYL-E-LITE	191	0	0	0	191
RENT OXY MED LIV 3000 SM		20	0	0	0	20
	OXYGEN USP LIV 3000 E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2540167
Invoice Date	08/21/2013
Invoice Number	48181418
Payment Due By	09/20/2013
Terms	Net 30 days
Invoice Total	$330.72

U.S. Dollars

MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Date: 08/15/2013 Order No: 110728733 Delivery No: 220128202
Delivery Location: WALLINGFORD - LG Ship To No: 2543895
PO Number: ANNIE Release: Shipped via: LINDE TRUCK

Material No.	Description	Shipped	Returned	Unit Price	Volume	Amount
109855	OXYGEN MEDICYL-E-LITE	47 CYL	38 CYL	5.79 CYL		272.08
109855	OXYGEN MEDICYL-E-LITE	1 CYL	0 CYL	5.79 CYL		5.79

DELIVERY CHARGE	38.09
COMPLIANCE CHG	8.95
ENERGY SURCHARGE	5.81
SUBTOTAL	330.72
TOTAL TAX	0.00
INVOICE TOTAL	$330.72

FOR INQUIRIES CALL: 1-866-543-3427

This invoice is subject to Terms and Conditions below

We may charge to you a regulatory compliance cost charge ("Compliance Charge"). The Compliance Charge results from the costs incurred by us in order to comply with federal, state, and local laws. However, those costs are difficult to calculate and apportion with precision. Therefore, the amount of the Compliance Charge is not related to actual compliance costs incurred by us, which may vary by the type of Product, service, geographic location, or time. The Compliance Charge is not a federal, state, or local tax, and we need not collect and pay the Compliance Charge to any federal, state, or local government. You shall pay all of our invoices within 30 days after the invoice date. Starting on the invoice date, we may charge interest on past due invoices at the lower of: (1) 1½% per month, or (2) the highest rate permitted by law. Due to the high cost of cylinders, it is important that you check your cylinder balances as shown above to see if they agree with your records. Call us immediately if there are any discrepancies. If we do not hear from you within 10 days of this invoice date, then we will consider your physical cylinder balances to agree with our records, and our records are binding. We will bill you for "loss of use" at current value for cylinders not returned or damaged. Save your returned cylinder receipts. If you and us have a signed contract and the terms of the signed contract conflict with these terms, then the terms of the signed contract govern.

PAYMENT SLIP

Please do not fold or staple

Invoice Number	48181418
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$330.72
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY ,NY 10017
Chips ABA # 0002 /Acct#304990647

EI130822 dat

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	08/29/2013
Invoice Number	48257020
Payment Due By	09/28/2013
Terms	Net 30 days
Invoice Total	$1,045.43

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 08/29/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	5870.00	0.158	927.46
OXYGEN USP OXY-GEN-1 ALUM DISS E	90.00	0.158	14.22
OXYGEN USP LIV 3000 E	600.00	0.158	94.80

Compliance Charge	8.95
Subtotal Amount	1045.43
Tax	0.00
Total	1045.43

FOR INQUIRIES CALL: 1-866-543-3427

This Invoice is subject to Terms and Conditions below

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PAYMENT SLIP

Please do not fold or staple

Invoice Number	48257020
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$1,045.43
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX130830.dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
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(Part 6)

INVOICE NO 48257020

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895 MT VERNON HOSPITAL 12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167 Mt VERNON HOSPITAL 16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		3	0	0	0	3
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		191	48	38	0	201
	OXYGEN MEDICYL-E-LITE	191	48	38	0	201
RENT OXY MED LIV 3000 SM		20	0	0	0	20
	OXYGEN USP LIV 3000 E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned
26001575	RENT MEDICYL-E-LITE				
109855	OXYGEN MEDICYL-E-LITE				
		08/16/2013	220128202	48	38

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2540167
Invoice Date	09/19/2013
Invoice Number	48366080
Payment Due By	10/19/2013
Terms	Net 30 days
Invoice Total	$330.73

U.S. Dollars

MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Date: 09/17/2013 **Order No:** 110842830 **Delivery No:** 220284000
Delivery Location: WALLINGFORD - LG **Ship To No:** 2543895
PO Number: Annie Manimala called in order. **Release:** **Shipped via:** LINDE TRUCK

Material No.	Description	Shipped	Returned	Unit Price	Volume	Amount
109855	OXYGEN MEDICYL-E-LITE	4 CYL	53 CYL	5.79 CYL		23.16
109855	OXYGEN MEDICYL-E-LITE	21 CYL	0 CYL	5.79 CYL		121.57
109855	OXYGEN MEDICYL-E-LITE	15 CYL	0 CYL	5.79 CYL		86.84
109855	OXYGEN MEDICYL-E-LITE	8 CYL	0 CYL	5.79 CYL		46.31

DELIVERY CHARGE	38.09
COMPLIANCE CHG	8.95
ENERGY SURCHARGE	5.81
SUBTOTAL	330.73
TOTAL TAX	0.00
INVOICE TOTAL	$330.73

FOR INQUIRIES CALL: 1-866-543-3427

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We may charge to you a regulatory compliance cost charge ("Compliance Charge"). The Compliance Charge results from the costs incurred by us in order to comply with federal, state, and local laws. However, those costs are difficult to calculate and apportion with precision. Therefore, the amount of the Compliance Charge is not related to actual compliance costs incurred by us, which may vary by the type of Product, service, geographic location, or time. The Compliance Charge is not a federal, state, or local tax, and we need not collect and pay the Compliance Charge to any federal, state, or local government. You shall pay all of our invoices within 30 days after the invoice date. Starting on the invoice date, we may charge interest on past due invoices at the lower of (1) 1½% per month, or (2) the highest rate permitted by law. Due to the high cost of cylinders, it is important that you check your cylinder balances as shown above to see if they agree with your records. Call us immediately if there are any discrepancies. If we do not hear from you within 10 days of this invoice date, then we will consider your physical cylinder balances to agree with our records, and our records are binding. We will bill you for "loss of use" at current value for cylinders not returned or damaged. Save your returned cylinder receipts. If you and us have a signed contract and the terms of the signed contract conflict with these terms, then the terms of the signed contract govern.

PAYMENT SLIP

Please do not fold or staple

Invoice Number	48366080
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$330.73
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EI130920.dat

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	09/27/2013
Invoice Number	48442441
Payment Due By	10/27/2013
Terms	Net 30 days
Invoice Total	$1,027.42

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 09/27/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	5779.00	0.158	913.08
OXYGEN USP OXY-GEN-1 ALUM DISS E	87.00	0.158	13.75
OXYGEN USP LIV 3000 E	580.00	0.158	91.64

Compliance Charge	8.95
Subtotal Amount	1027.42
Tax	0.00
Total	1027.42

FOR INQUIRIES CALL: 1-866-543-3427

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PAYMENT SLIP

Please do not fold or staple

Invoice Number	48442441
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$1,027.42
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail

Detach this payment slip and mail with payment

By Credit Card

Payment can be made by calling 1-800-348-3349

By ACH

ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX130929.dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Pg 31 of 35
(Part 6)

INVOICE NO 48442441

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895 MT VERNON HOSPITAL 12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167 Mt VERNON HOSPITAL 16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		3	0	0	0	3
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		201	48	53	0	196
	OXYGEN MEDICYL-E-LITE	201	48	53	0	196
RENT OXY MED LIV 3000 SM		20	0	0	0	20
	OXYGEN USP LIV 3000 E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned
26001575	RENT MEDICYL-E-LITE				
109855	OXYGEN MEDICYL-E-LITE				
		09/18/2013	220284000	48	53

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

ORIGINAL INVOICE

Customer Number	2540167
Invoice Date	10/24/2013
Invoice Number	48588192
Payment Due By	11/23/2013
Terms	Net 30 days
Invoice Total	$330.74

U.S. Dollars

MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Date: 10/23/2013 **Order No:** 110968354 **Delivery No:** 220462196
Delivery Location: WALLINGFORD - LG **Ship To No:** 2543895
PO Number: Annie- 914-361-6048 **Release:** **Shipped via:** LINDE TRUCK

Material No.	Description	Shipped	Returned	Unit Price	Volume	Amount
109855	OXYGEN MEDICYL-E-LITE	4 CYL	38 CYL	5.79 CYL		23.16
109855	OXYGEN MEDICYL-E-LITE	5 CYL	0 CYL	5.79 CYL		28.95
109855	OXYGEN MEDICYL-E-LITE	35 CYL	0 CYL	5.79 CYL		202.62
109855	OXYGEN MEDICYL-E-LITE	2 CYL	0 CYL	5.79 CYL		11.58
109855	OXYGEN MEDICYL-E-LITE	2 CYL	0 CYL	5.79 CYL		11.58

DELIVERY CHARGE	38.09
COMPLIANCE CHG	8.95
ENERGY SURCHARGE	5.81
SUBTOTAL	330.74
TOTAL TAX	0.00
INVOICE TOTAL	$330.74

FOR INQUIRIES CALL: 1-866-543-3427

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PAYMENT SLIP

Please do not fold or staple

Invoice Number	48588192
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$330.74
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-800-348-3349

By ACH
ACH costs less and is more secure than checks:

Chase ABA#021000021
Swift: CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EI131028.dat

LifeGas

575 MOUNTAIN AVE
NEW PROVIDENCE NJ 07974-2097

RENTAL INVOICE

Customer Number	2540167
Invoice Date	10/30/2013
Invoice Number	48643508
Payment Due By	11/29/2013
Terms	Net 30 days
Invoice Total	$1,161.87

MT VERNON HOSPITAL
12 N 7TH AVE
MOUNT VERNON.NY 10550-2026

SHIP TO:
MT VERNON HOSPITAL
ATT NICK D'ADDESIO
12 N 7TH AVE
MOUNT VERNON NY 10550-2026

Period End Date: 10/30/2013
Rental Type: DAILY
Purchase Order Number:

Ship To Account Number: 2543895

Description	Total Days	Rate	Amount
OXYGEN MEDICYL-E-LITE	6538.00	0.158	1033.00
OXYGEN USP OXY-GEN-1 ALUM DISS E	99.00	0.158	15.64
OXYGEN USP LIV 3000 E	660.00	0.158	104.28

Compliance Charge	8.95
Subtotal Amount	1161.87
Tax	0.00
Total	1161.87

FOR INQUIRIES CALL: 1-888-290-3590

This invoice is subject to Terms and Conditions below

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PAYMENT SLIP

Please do not fold or staple

Invoice Number	48643508
Customer Name	Mt VERNON HOSPITAL
Customer Number	2540167
Amount Due	$1,161.87
Remit to	LINDE GAS NORTH AMERICA LLC 24963 NETWORK PLACE CHICAGO IL 60673-1249

By Mail
Detach this payment slip and mail with payment

By Credit Card
Payment can be made by calling 1-888-290-3590

By ACH
ACH costs less and is more secure than checks

Chase ABA#021000021
Swift. CHASUS33 / 270 Park Avenue / NY.,NY 10017
Chips ABA # 0002 /Acct#304990647

EX131031.dat

13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 6) Pg 34 of 35

INVOICE NO 48643508

RENTAL INVOICE DATA REPORT

SOLD TO: 2543895 MT VERNON HOSPITAL 12 N 7TH AVE, MOUNT VERNON, NY, 10550-2026
PAYER: 2540167 Mt VERNON HOSPITAL 16 GUION PL, NEW ROCHELLE, NY, 10801-5502

RENTAL CALCULATION

Group Description	Product Description	Begin Bal	Shipped	Returned	Adj	End Bal
RENT OXY-GEN 1		**3**	**0**	**0**	**0**	**3**
	OXYGEN USP OXY-GEN-1 ALUM DISS E	3	0	0	0	3
RENT MEDICYL-E-LITE		**196**	**48**	**38**	**0**	**206**
	OXYGEN MEDICYL-E-LITE	196	48	38	0	206
RENT OXY MED LIV 3000 SM		**20**	**0**	**0**	**0**	**20**
	OXYGEN USP LIV 3000 E	20	0	0	0	20

SERIAL NUMBER DETAILS

Material No	Product Description	Serial Number	Serial Number	Serial Number	Serial Number

TRANSACTIONAL DETAILS

Material No	Description	Delivery Date	Delivery Document	Shipped	Returned
26001575	RENT MEDICYL-E-LITE				
109855	OXYGEN MEDICYL-E-LITE				
		10/24/2013	220462196	48	38

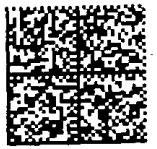
13-22840-rdd Doc 1139-8 Filed 06/29/15 Entered 06/29/15 Claims
(Part 6) Pg 35 of 35

THE LINDE GROUP

Linde

575 Mountain Avenue
Murray Hill, NJ 07974

91 7108 2133 3937 7470 4476



U.S. POSTAGE PITNEY BOWES

ZIP 07974 $ 008.24⁰
02 1W
0001367090 MAR 17. 2014

SoundStore Medical of Westchester et al.,
C/O GCG, INC.,
P.O. Box 9982
DUBLIN, OH 43017-5982

UNITED STATES 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	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)
Lisa A. Marrero, M.D.

☐ 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. MAY - 1 2014

Name and Addresses Where Notices Should be Sent.
30 Harvard Ct.
White Plains, NY 10605

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:
098-68-9438

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: Employee Medical Malpractice

2. DATE DEBT WAS INCURRED (IF KNOWN): 7/23/07 - 11/5/13

3. DESCRIPTION OF CLAIM (IF KNOWN): Extended Reporting Coverage (Tail) Primary Profession Liability Policy 88181

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 26,319 (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: LISA A. MARRERO MD
Title: _____
Company: _____
Address and telephone number (if different from notice address above).
30 HARVARD COURT
WHITE COURT NEW YORK 10605
Telephone number: 914-420-6034

Lisa A. Marrero MD (Signature) 4-26-2014 (Date)

email: lamarreromd@msn.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.

Lisa A. Marrero MD FAAP
30 Harvard Court
White Plains NY 10605

April 27, 2014

United States Bankruptcy Court
Southern District of New York

Re:Admistrative Expense Proof of Claim

Your Honor:

Enclosed is the invoice that I've paid to Physicians Reciprocal Insurers, as well as the proof of claim form for malpractice claims made "tail" coverage for the work I did as an employee of Sound Shore Medical Center. I am a pediatrician, and I've worked for SSMC since I graduated from residency in their outpatient clinic. I have paid the tail because I believed it was the surest way to insure for any malpractice claims in the future, and because Sound Shore Medical Center did not assume this heavy expense for me.

The amount I am claiming is $26,319. It represents a large portion of my savings, and so I would like to express that I believe it is fairly requested, and that I would appreciate a favorable judgment. Thank you for your attention

Very truly yours,

Lisa A. Marrero, MD FAAP

INVOICE

December 9, 2013

Sound Shore Medical Center of Westchester
16 Guion Place
New Rochelle, NY 10801
Attn: Dr. Margaret Levitt

Re: Primary Professional Liability
Sound Shore Medical Center
Extended Reporting Period (Tail Coverage)

Primary Professional Liability Policy # 88181

Extended Reporting Coverage- Dr. Lisa A. Marrero

Policy Effective Dates- 7/23/2007 – 11/5/2013

Tail Premium Due: **$26,319**

Please make check payable to: **Physicians' Reciprocal Insurers**

Mail to: Jeanne H. Braun, Executive Vice President
Hospitals & Special Programs
Physicians' Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11576

Due Date: March 6, 2014

**** Additional premium is an offer to purchase extended reporting coverage (tail). If no payment is made in 30 days we will assume you have declined to purchase extended reporting coverage.**

citi

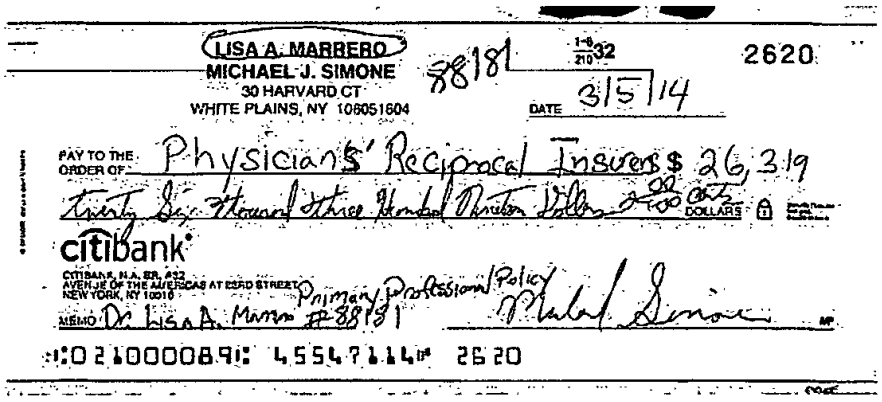
Print a Copy Cl

ATM/Debit Card: XXXX-XXXX-XXXX-7788

As of 04-27-2014 18:30 EDT

SERVICES Check Details

Account	Check #	Post Date	Amount
Checking: 7114 2620		03/10/2014	$ 26,319.00



LISA A. MARRERO
MICHAEL J. SIMONE
30 HARVARD CT
WHITE PLAINS, NY 106051604

88181 1-6/210 32 2620

DATE 3/5/14

PAY TO THE ORDER OF Physicians' Reciprocal Insurers $ 26,319

Twenty Six Thousand Three Hundred Nineteen Dollars 00 Cts DOLLARS

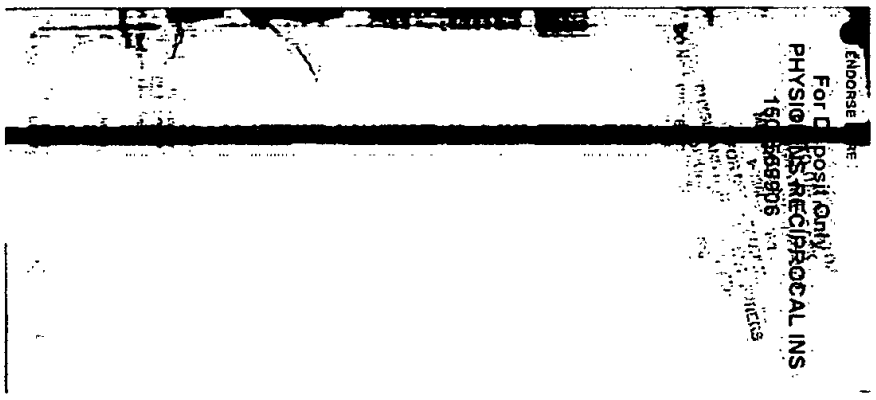
citibank

CITIBANK, N.A. SR. 332
AVENUE OF THE AMERICAS AT 52ND STREET
NEW YORK, NY 10019

MEMO Dr Lisa A. Marrero #88181 Primary Professional Policy

Michael Simone

⑆021000089⑆ 4554?114⑈ 2620



ENDORSE

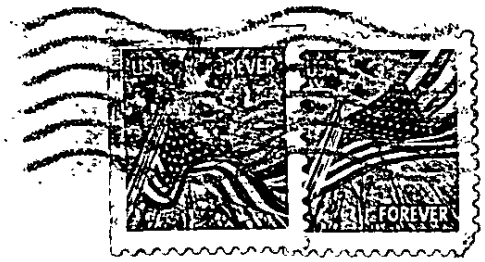
For Deposit Only
PHYSICIANS RECIPROCAL INS

Security Tip: Check Image files may be automatically saved on the hard drive of this computer. If other people use this computer you should delete these files so that no one will have access to your check images and account information. Learn more

13-22840-rdd Doc 1139-9 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 7) Pg 5 of 28

WESTCHESTER NY 105

28 APR 2014 PM 2 L



Sound Shore Medical of Westchester
c/o G.C.G., Inc.
PO Box 9982
Dublin, OHIO
43017-5982

Administrative Expense
Proof of Claim

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/aHelen 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)
MARTAB MEDICAL

☐ 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 11 2014

Name and Addresses Where Notices Should be Sent:
40 BOROLINE ROAD
ALLENDALE, NJ 07401

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) MEDICAL EQUIPMENT RENTAL
☐ Money loaned ☐ Taxes ☐ Retiree Benefits as Defined in 11 U.S.C. § 1114(a) ☑ Other(Specify):

2. DATE DEBT WAS INCURRED (IF KNOWN): SEE ATTACHED INVOICES

3. DESCRIPTION OF CLAIM (IF KNOWN): SEE ATTACHED INVOICES

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 2,450.00 (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: ANTHONY R. MARMO
Title: CEO
Company: MARTAB MEDICAL
Address and telephone number (if different from notice address above):
SAME AS ABOVE
Telephone number: 201 512-1100 X225

(Signature) (Date)

email: amarmo@martab.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

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FILED - 01458
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Martab
MEDICAL
40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 02-0230175-0000-201306
INVOICE DATE: 7/1/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

SOLDTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit						1				350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3410296	06/30/2013	NR171029	130352	06/01/2013	06/30/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	02-0230175-0000-201306	8/5/2013	350.00	0.00	0.00	350.00

40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 02-0230175-0000-201307

INVOICE DATE: 7/31/2013

SALESPERSON: A01

CUSTOMER NUMBER: 02-0230175

SOLDTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit						1				350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3411348	07/31/2013	NR171029	130352	07/01/2013	07/31/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	02-0230175-0000-201307	9/4/2013	350.00	0.00	0.00	350.00

Martab
MEDICAL
40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 02-0230175-0000-201308
INVOICE DATE: 08/31/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

SOLDTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit									1	350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3412466	08/31/2013	NR171029	130352	08/01/2013	08/31/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	02-0230175-0000-201308	10/5/2013	350.00	0.00	0.00	350.00

Martab
MEDICAL

40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 02-0230175-0000-201309
INVOICE DATE: 09/30/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

SOLDTO:
Sound Shore Med Ctr of
Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of
Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit									1	350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3413504	09/30/2013	NR171029	130352	09/01/2013	09/30/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	02-0230175-0000-201309	11/5/2013	350.00	0.00	0.00	350.00

Martab
MEDICAL
40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 0202301750000201310

INVOICE DATE: 10/31/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

SOLDTO:
Sound Shore Med Ctr of
Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of
Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit						1				350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3415820	10/31/2013	NR171029	130352	10/01/2013	10/31/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	0202301750000201310	12/5/2013	350.00	0.00	0.00	350.00

Martab
MEDICAL
40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 0202301750000201311

INVOICE DATE: 11/30/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

SOLDTO:
Montefiore New Rochelle Hosp
Formerly Sound Shore Hosp
200 Corporate Boulevard South
Suite 175-Accounts Payable
YONKERS, NY 10701

SHIPTO:
Sound Shore Med Ctr of
Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit										350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3416763	11/30/2013	NR171029	130352	11/01/2013	11/30/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	0202301750000201311	1/5/2014	350.00	0.00	0.00	350.00

Martab
MEDICAL
40 Boroline Road
Allendale, NJ 07401
Phone: (201) 512-1100
Fax: (201) 512-0105

RENTAL INVOICE: 02-0230175-0000-201305
INVOICE DATE: 5/31/2013
SALESPERSON: A01
CUSTOMER NUMBER: 02-0230175

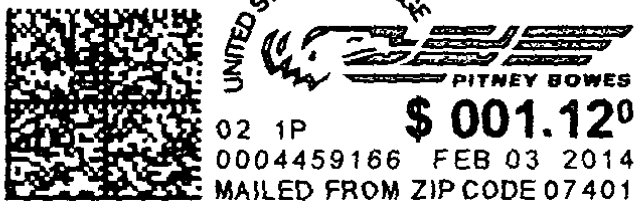
SOLDTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

SHIPTO:
Sound Shore Med Ctr of Westchester
16 Guion Place
New Rochelle, NY 10801

BiPap Vision Unit						1				350.00
Reference #	InvoiceDate	CustomerPONo	SerialNo	START DATE	END DATE	PERIODS	RCODE	RATE	QTY	Amount:
3409105	05/31/2013	NR171029	130352	05/01/2013	05/31/2013	1	M	350.00	1	350.00
										350.00

CUSTOMER #	INVOICE#	DUE DATE	Subtotal:	Freight:	SalesTax:	Total:
02-0230175	02-0230175-0000-201305	7/5/2013	350.00	0.00	0.00	350.00

13-22840-rdd Doc 1139-9 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 7) Pg 14 of 28



Martab Medical
40 Boroline Road
Allendale, NJ 0701
www.martab.com

To: SOUND SHORE MEDICAL OF WESTCHESTER, et al
C/O GCG, INC.
P O BOX 9982
DUBLIN, OH 43017-5982

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)

Modern Medical Systems Co.

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:

Arent Fox LLP
c/o Robert M. Hirsh, Esq.
1675 Broadway
New York, NY 10019-5820

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

Claim Number (if known): _____

Dated: 1/10/14

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): Administrative

FILED - 01356
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 30,406.98 (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: Robert M. Hirsh, Esq.
Title: Partner
Company: Arent Fox LLP
Address and telephone number (if different from notice address above):

_____
_____
_____
Telephone number: 212-484-3900

(Signature) _____ (Date) 1/31/14

email: robert.hirsh@arentfox.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.

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Arent Fox

Arent Fox LLP / Attorneys at Law
Los Angeles, CA / New York, NY / San Francisco, CA / Washington, DC
www.arentfox.com

January 31, 2014

Nova A. Alindogan
Sr. Legal Assistant
212.457.5416 DIRECT
212.484.3990 FAX
nova.alindogan@arentfox.com

VIA FEDERAL EXPRESS

Sound Shore Medical Center of Westchester
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, OH 43017

Re: Sound Shore Medical Center of Westchester, et al.
Case No. 13-22840

The Mount Vernon Hospital, Inc.
Case No. 13-22841

Dear Sir/Madam:

Enclosed please find an original and two (2) copies of the amended proof of claims of Modern Medical Systems Co. in the above referenced cases.

Kindly file the original and stamp and return the two (2) copies of each claim to me in the enclosed FedEx envelope, using the waybill which has been provided.

Thank you for your assistance. Please call the undersigned at (212) 457-5416 should you have any questions.

Sincerely,

Nova A. Alindogan

Nova A. Alindogan

AFDOCS/10663854.1

Mt. Vernon Receivable
Interest Calculation

Invoice Date	Amount	Customer	Days Outstanding	Interest
1-Oct-13	$ 23,685.77	Mount Vernon	123	$ 399.09
1-Nov-13	$ 5,526.71	Mount Vernon	93	$ 70.41
	$ 29,212.48			$ 469.50

MMS
A KINGSBURY CO., INC.

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257

Invoice #	353802
Date	5/28/2013
Page	Page 1 of 1

BILL TO:

Mount Vernon Hospital
12 North Seventh Avenue
Accounts Payable
Mount Vernon, NY 10550

SHIP TO:

Mount Vernon Hospital
Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550-1118

P.O. NUMBER	CUSTOMER NO	SALESPERSON	TERMS	
139969	0011085	amason	NET 90	

HRS/QTY	DESCRIPTION	WORK ORDER	RESOURCE	DATE	UNIT PRICE	EXT PRICE
	Service					
	Blue light on, unit driving slow. Call Deceald Dispatch using CSR # JH-2080					
	Part					
1.00	SUB/PART - Part - Vendor supplied part	446086	dbleistein	5/28/2013	$0.00	$0.00
1.00	SUB/LABOR - Part - Sub/Labor	446086	dbleistein	5/28/2013	$725.00	$725.00

False alarm causing locked wheels

Repaired by vendor
Tue May 28 08:03:21 EDT 2013 DBLEISTEIN

Tue May 28 10:02:32 EDT 2013 DKNOX
Found tube park switch intermittently not staying engaged, causing blue light, and slow operation during transport.
-Found park sensor switch lever out of adjustment, sensor lever bent.
Was able to adjust lever, and calibrate.
-Unit working okey now, if problem persists, new switch assembly will be necessary.
NOTE. This equipment is not covered by contract. P O # 139969 will be used for this adjustment.

Work Type	Item	
Corrective Maintenance	Radiographic Units, Mobile	
Asset Number	***Serial Number***	***Model Number***
tmvh-1434	0462Z15705	MUX-100H

SUBTOTAL	$725.00
	$0.00
INVOICE TOTAL	$725.00

MMS
A KINGSBURY CO., INC.

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257

Invoice #	399959
Date	10/1/2013
Page	Page 1 of 1

BILL TO

Mount Vernon Hospital
12 North Seventh Avenue
Accounts Payable
Mount Vernon, NY 10550

CONTRACT	CONTRACT PERIOD	BILLING PERIOD
100033	8/1/2009 to 7/31/2014	10/1/2013 to 10/31/2013

P.O. NUMBER	CUSTOMER NO.	SALESPERSON	TERMS	BILLING INTERVAL
MV19351	0011085	House Account	NET 30	Monthly

HRS/QTY	DESCRIPTION	SERIAL #	UNIT PRICE	EXT. PRICE
1	Contract Payment		$23,685.77	$23,685.77

Prostaff Contract

SUBTOTAL	$23,685.77
TAX	$0.00
INVOICE TOTAL	$23,685.77

MMS

A KINGSBURY CO., INC

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257

Invoice #	413857
Date	11/1/2013
Page	Page 1 of 1

BILL TO:

Mount Vernon Hospital
12 North Seventh Avenue
Accounts Payable
Mount Vernon, NY 10550

CONTRACT	CONTRACT PERIOD	BILLING PERIOD
100033	8/1/2009 to 7/31/2014	11/1/2013 to 11/7/2013

P.O. NUMBER	CUSTOMER NO.	SALESPERSON	TERMS	BILLING INTERVAL
MV19351	0011085	House Account	NET 30	Monthly

HRS/QTY	DESCRIPTION	SERIAL #	UNIT PRICE	EXT. PRICE
1	Contract Payment		$5,526.71	$5,526.71

Prostaff Contract

SUBTOTAL	$5,526.71
	$0.00
INVOICE TOTAL	$5,526.71

From: (212) 457-5416
Nova Alindogan
Arent Fox LLP
1675 Broadway

New York, NY 10019

Origin ID: QNYA

FedEx Express

J14101312270326

Ship Date: 31JAN14
ActWgt: 1.0 LB
CAD: 100666945/INET3490

Delivery Address Bar Code

Ref # 032407.00014
Invoice #
PO #
Dept #

SHIP TO: (800) 327-3664 BILL SENDER
SoundShore Med. Ctr. of Westcheste
c/o GCG
5151 BLAZER PKWY STE A

DUBLIN, OH 43017

MON - 03 FEB 10:30A
PRIORITY OVERNIGHT

TRK# 7977 8770 6710
0201

SB OSUA

43017
OH-US
LCK

522G1/D6EC/F220

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)

Modern Medical Systems Co.

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:

Arent Fox LLP
c/o Robert M. Hirsh, Esq.
1675 Broadway
New York, NY 10019-5820

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

Claim Number (if known): _____

Dated: 1/10/14

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): Administrative

FILED - 01357
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 69,838.64 (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: Robert M. Hirsh, Esq.
Title: Partner
Company: Arent Fox LLP
Address and telephone number (if different from notice address above).

(Signature) 1/31/14 (Date)

Telephone number: 212-484-3900 email: robert.hirsh@arentfox.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.

Sound Shore Receivable
Interest Calculation

Invoice Date	Amount	Customer	Days Outstanding	Interest
1-Sep-13	$ 5,833.33	Sound Shore	153	$ 122.26
1-Oct-13	$ 50,941.57	Sound Shore	123	$ 858.33
1-Oct-13	$ 2,285.30	Sound Shore	123	$ 38.51
1-Nov-13	$ 11,886.42	Sound Shore	93	$ 151.43
1-Nov-13	$ 533.26	Sound Shore	93	$ 6.79
	$ 71,479.88			$ 1,177.32

Arent Fox

Arent Fox LLP / Attorneys at Law
Los Angeles, CA / New York, NY / San Francisco, CA / Washington, DC
www.arentfox.com

January 31, 2014

Nova A. Alindogan
Sr. Legal Assistant
212.457.5416 DIRECT
212.484.3990 FAX
nova.alindogan@arentfox.com

VIA FEDERAL EXPRESS

Sound Shore Medical Center of Westchester
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, OH 43017

Re: Sound Shore Medical Center of Westchester, et al.
Case No. 13-22840

The Mount Vernon Hospital, Inc.
Case No. 13-22841

Dear Sir/Madam:

Enclosed please find an original and two (2) copies of the amended proof of claims of Modern Medical Systems Co. in the above referenced cases.

Kindly file the original and stamp and return the two (2) copies of each claim to me in the enclosed FedEx envelope, using the waybill which has been provided.

Thank you for your assistance. Please call the undersigned at (212) 457-5416 should you have any questions.

Sincerely,

Nova A. Alindogan

AFDOCS/10663854.1

MMS

A. KINGSBURY CO., INC

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257

Invoice #	392415
Date	9/1/2013
Page	Page 1 of 1

BILL TO:

Sound Shore Medical Center
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10801-5503

CONTRACT	CONTRACT PERIOD	BILLING PERIOD
100032	8/1/2008 to 7/31/2014	9/1/2013 to 9/30/2013

P.O NUMBER	CUSTOMER NO	SALESPERSON	TERMS	BILLING INTERVAL
NR151162	0011129	House Account	NET 30	Monthly

HRS/QTY	DESCRIPTION	SERIAL #	UNIT PRICE	EXT PRICE
1	Contract Payment		$50,941.57	$50,941.57

Prostaff Contract

SUBTOTAL	$50,941.57
	$0.00
INVOICE TOTAL	$50,941.57

Pd 45,108.24

Balance 5,833.33

MMS

A KINGSBURY CO., INC

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257

Invoice #	399958
Date	10/1/2013
Page	Page 1 of 1

BILL TO:

Sound Shore Medical Center
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10801-5503

CONTRACT	CONTRACT PERIOD	BILLING PERIOD
100032	8/1/2009 to 7/31/2014	10/1/2013 to 10/31/2013

P.O. NUMBER	CUSTOMER NO.	SALESPERSON	TERMS	BILLING INTERVAL
NR151162	001.1129	House Account	NET 30	Monthly

HRS/QTY	DESCRIPTION	SERIAL #	UNIT PRICE	EXT. PRICE
1	Contract Payment		$50,941.57	$50,941.57

Prostaff Contract

SUBTOTAL	$50,941.57
	$0.00
INVOICE TOTAL	$50,941.57

MMS
A KINGSBURY CO., INC.

MODERN MEDICAL SYSTEMS
170 FINN COURT, SUITE 1
FARMINGDALE, NY 11735
1-800-736-8257.

Invoice #	413856
Date	11/1/2013
Page	Page 1 of 1

BILL TO:

Sound Shore Medical Center
Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10801-5503

CONTRACT	CONTRACT PERIOD	BILLING PERIOD
100032	8/1/2009 to 7/31/2014	11/1/2013 to 11/7/2013

P.O. NUMBER	CUSTOMER NO	SALESPERSON	TERMS	BILLING INTERVAL
NR151162	0011129	House Account	NET 30	Monthly

HRS/QTY	DESCRIPTION	SERIAL #	UNIT PRICE	EXT PRICE
1	Contract Payment		$11,886.42	$11,886.42

Prostaff Contract

SUBTOTAL	$11,886.42
	$0.00
INVOICE TOTAL	$11,886.42

From: (212) 457-5416
Nova Alindogan
Arent Fox LLP
1675 Broadway

New York, NY 10019

Origin ID: QNYA

FedEx Express

J14101312270326

Ship Date: 31JAN14
ActWgt: 1.0 LB
CAD: 100666945/INET3490

Delivery Address Bar Code

Ref # 032407.00014
Invoice #
PO #
Dept #

SHIP TO: (800) 327-3664 BILL SENDER
SoundShore Med. Ctr. of Westcheste
c/o GCG
5151 BLAZER PKWY STE A

DUBLIN, OH 43017

MON - 03 FEB 10:30A
PRIORITY OVERNIGHT

TRK# 0201 **7977 8770 6710**

SB OSUA

43017
OH-US
LCK

522G1/D6EC/F220

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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)
National Dust Control Services Corp.

☐ 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 - 3 2014

Name and Addresses Where Notices Should be Sent:
National Dust Control Services Corp.
200 Blackford Ave.
Middlesex, NJ 08846

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): Mat Rental

FILED - 01354
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 5,370.00 (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: Bryan Stock
Title: Vice-President
Company: _____
Address and telephone number (if different from notice address above):

(Signature) 01/28/14 (Date)

Telephone number: (732) 748-8700 ext. 224 email: BryanStock@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

NATIONAL DUST CONTROL
200 Blackford Ave,
Middlesex, NJ 08846
Phone 1-800-238-2387 Fax (732) 748-8888

Statement of Account For:

SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE, NY 10801-

Please Remit To:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Customer Number: 8091-0		Statement Date: 05-Jan-2014			Page 1 of 2
Invoice Date	**Invoice #**	**Service Amt.**	**Check No.**	**Check Amt.**	**Balance**
17-Apr-2012	134789	139.00			139.00
15-May-2012	138483	139.00			139.00
12-Jun-2012	142155	139.00			139.00
10-Jul-2012	145894	139.00			139.00
07-Aug-2012	149519	139.00			139.00
04-Sep-2012	153169	139.00			139.00
02-Oct-2012	156775	139.00			139.00
30-Oct-2012	160381	139.00			139.00
27-Nov-2012	164068	139.00			139.00
25-Dec-2012	167646	139.00			139.00
22-Jan-2013	171303	139.00			139.00
19-Feb-2013	174935	139.00			139.00
19-Mar-2013	178579	139.00			139.00
16-Apr-2013	182183	139.00			139.00
14-May-2013	185741	139.00			139.00

Balance Owing is due on receipt of this statement. Terms: 3% per month compounded.

Current	30-60 Days	60-90 Days	Over 90 Days	Balance Owing
				Continued on Page 2

Please tear here and send with your remittance

Remittance advice for: 8091-0

SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE, NY 10801-

As of Date
05-Jan-2014

Invoice #	Balance	☑
134789	139.00	
138483	139.00	
142155	139.00	
145894	139.00	
149519	139.00	
153169	139.00	
156775	139.00	
160381	139.00	
164068	139.00	
167646	139.00	
171303	139.00	
174935	139.00	
178579	139.00	
182183	139.00	
185741	139.00	

Please Remit to:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Please indicate the invoices you are paying by placing a check mark beside the invoice/balance above.

NATIONAL DUST CONTROL
200 Blackford Ave,
Middlesex, NJ 08846
Phone 1-800-238-2387 Fax (732) 748-8888

Statement of Account For:

SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE, NY 10801-

Please Remit To:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Customer Number: 8091-0 **Statement Date: 05-Jan-2014** **Page 2 of 2**

Invoice Date	Invoice #	Service Amt.	Check No.	Check Amt.	Balance
11-Jun-2013	189295	139.00			139.00
09-Jul-2013	192896	139.00			139.00
06-Aug-2013	196398	139.00			139.00
03-Sep-2013	199924	139.00			139.00
01-Oct-2013	203473	139.00			139.00
29-Oct-2013	206998	139.00			139.00

Balance Owing is due on receipt of this statement. Terms: 3% per month compounded.

Current	30-60 Days	60-90 Days	Over 90 Days	Balance Owing
0.00	0.00	139.00	2,780.00	$2,919.00

Please tear here and send with your remittance

Remittance advice for: 8091-0

SOUND SHORE MEDICAL CENTER
ATTN: ACCOUNTS PAYABLE
16 GUION PLACE
NEW ROCHELLE, NY 10801-

As of Date
05-Jan-2014

Amount Due:
$2,919.00

Amount Enclosed

Please Remit to:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Invoice #	Balance	☑
189295	139.00	
192896	139.00	
196398	139.00	
199924	139.00	
203473	139.00	
206998	139.00	

Please indicate the invoices you are paying by placing a check mark beside the invoice/balance above.

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No.	Invoice Date	Page
134789	17-Apr-2012	1/1

Customer No.	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

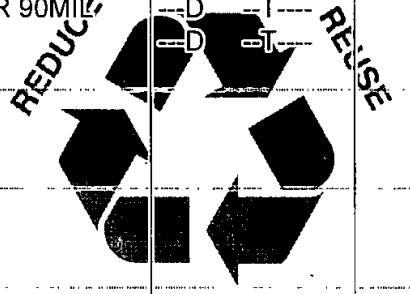
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D ---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D ---T----	0	0	*	



Sub Total					This Service		Grand Total
$139.00	NY 0.00%	0.00			$139.00		$139.00

See reverse side for additional company information.

RECEIVED BY: _____

CUSTOMER COPY

All products remain the property of National Dust Control
The above products received in good condition except as noted.
Customer is responsible for loss or damage.

DO NOT DESTROY. THIS IS YOUR INVOICE.
TERMS: Net 30 - 2% per month compounded on Overdue Balance.

All items will be cleaned and maintained by National Dust Control (the Company). All items that require replacement due to normal wear will be replaced by the Company at no charge to the Customer.

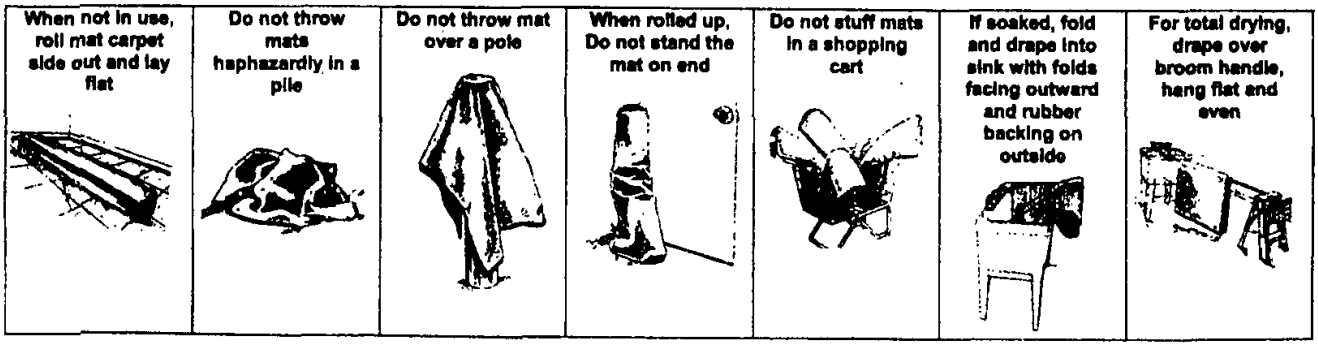
All items remain the property of the Company. In the event items are lost, stolen, or destroyed by fire, acid, paint, gross neglect, or otherwise, the customer will pay for said items at the current replacement value. Customer agrees to notify Company, in writing, of any hazardous materials that may be picked up by Company in the soiled textiles serviced under this agreement. In no case will hazardous materials be present to the extent that they may be harmful to Company's employees.

Customer shall defend and indemnify National Dust Control and hold National Dust Control harmless from and against any and all claims, losses, damages and expenses, including reasonable attorneys' fees and disbursements, resulting from personal injury, bodily injury (including death) and property damage which in any way involves Customer's use of mats rented from National Dust Control, including all claims for product defects and regardless of any action or inaction on the part of National Dust Control.

The company guarantees to deliver the highest quality textile rental service at all times. Any concerns about the quality of our products and services please call our customer service department at 800-238-2387. Company mats are placed in designated areas and should not be moved. If Customer requires any changes to mat placements, mat removals, or mat relocations, Customer must contact Company prior to any such changes.

Customers not currently bound by a service agreement with the Company must give the Company 30 days written notice prior to any cancellations.

INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
138483	15-May-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

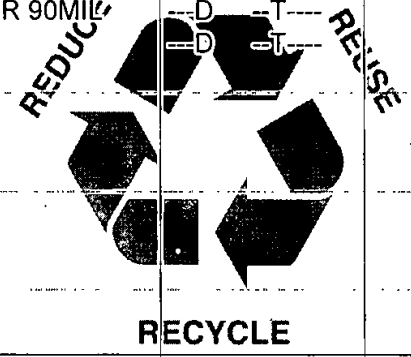
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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CUSTOMER COPY

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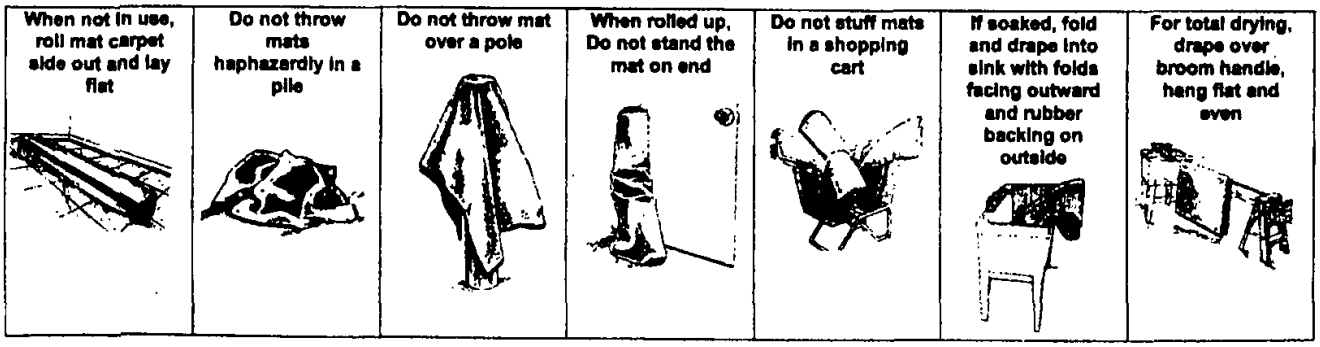
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
142155	12-Jun-2012	1/1

Customer No	Route	Key
8091-0	108	1

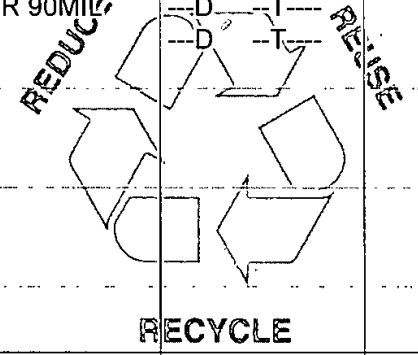
Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information
8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

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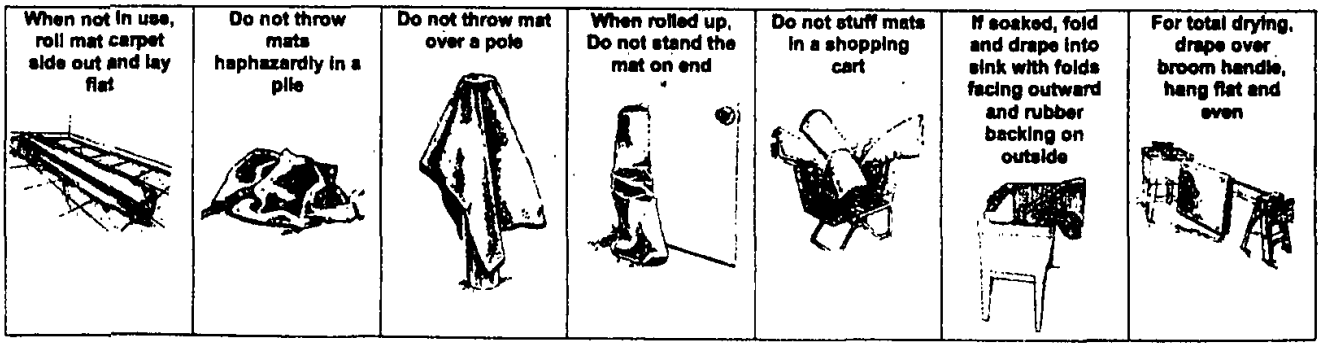

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
145894	10-Jul-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

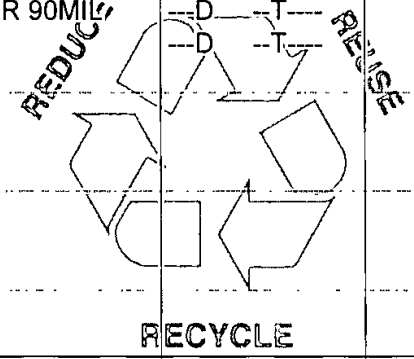
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

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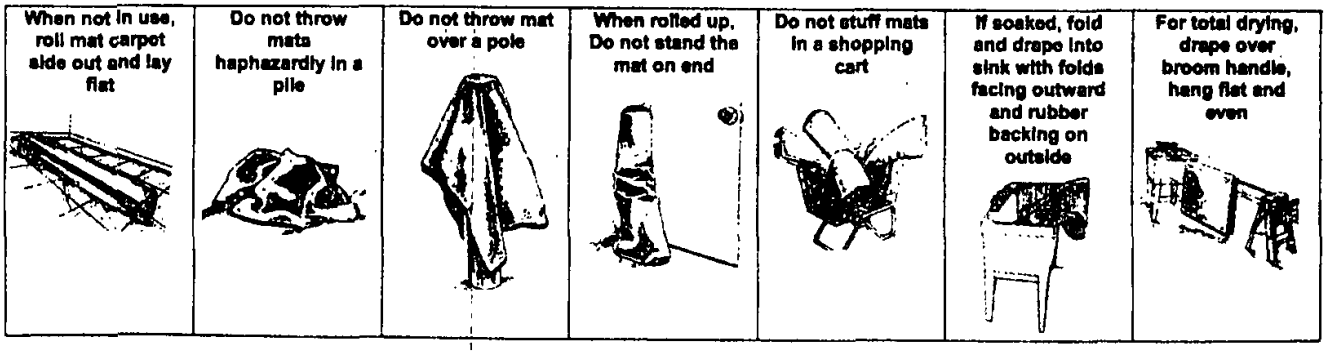

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
149519	07-Aug-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

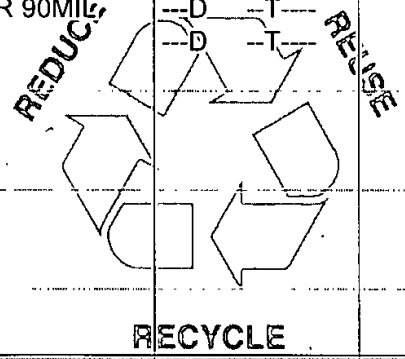
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information
8091-0 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service*	Grand Total*
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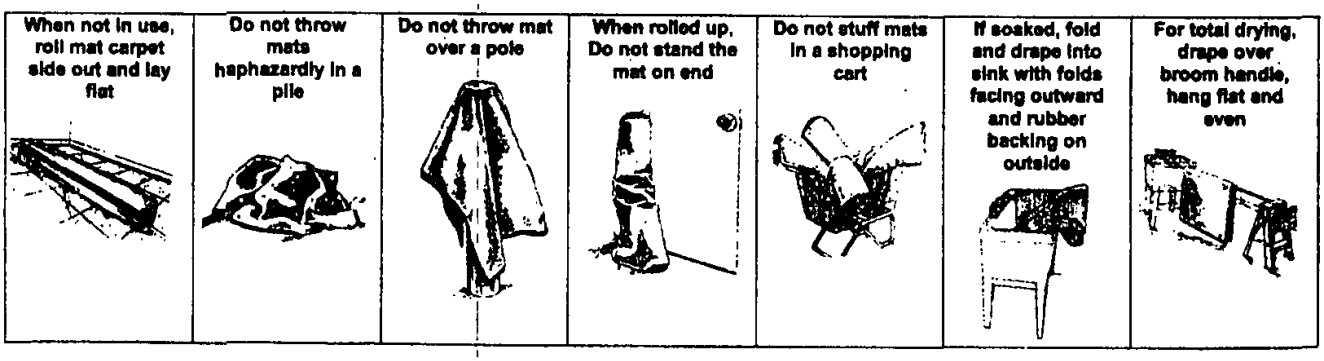

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
153169	04-Sep-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

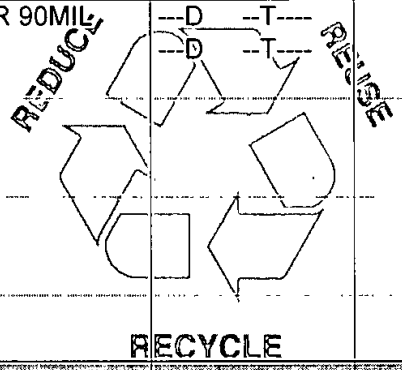
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90MIL - 5X20 CH HEATHER 90MIL	---D --T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D --T----	0	0	*	



Sub Total	NY				This Service		Grand Total
$139.00	0.00%	0.00			$139.00		$139.00

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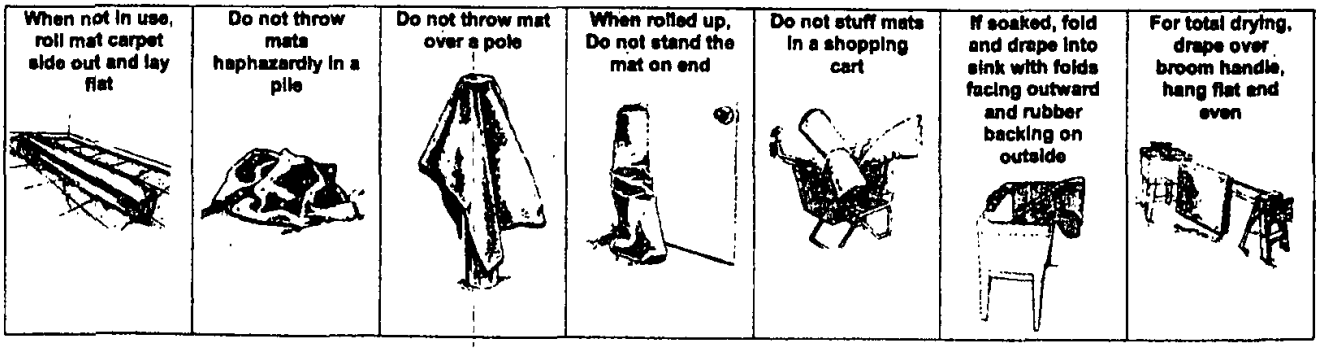

200 Blackford Avenue
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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
156775	02-Oct-2012	1/1

Customer No	Route	Key
8091-0	108	1

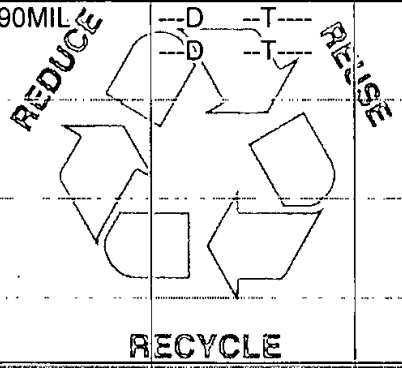
Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information
8091-0 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D --T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D --T----	0	0	*	



Sub Total	NY			This Service	Grand Total
$139.00	0.00%	0.00		$139.00	$139.00

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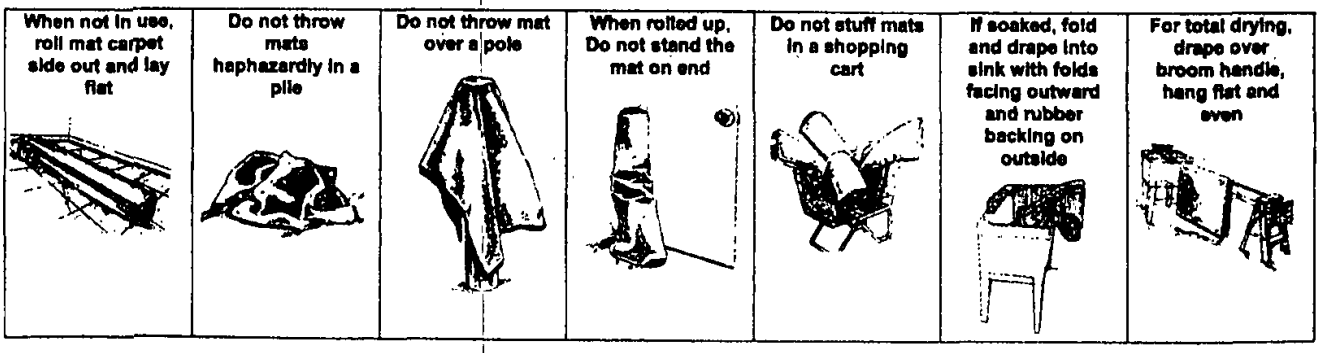

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QUALITY AND SERVICE SINCE 1970

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
160381	30-Oct-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

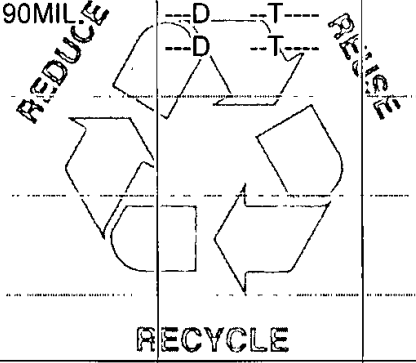
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
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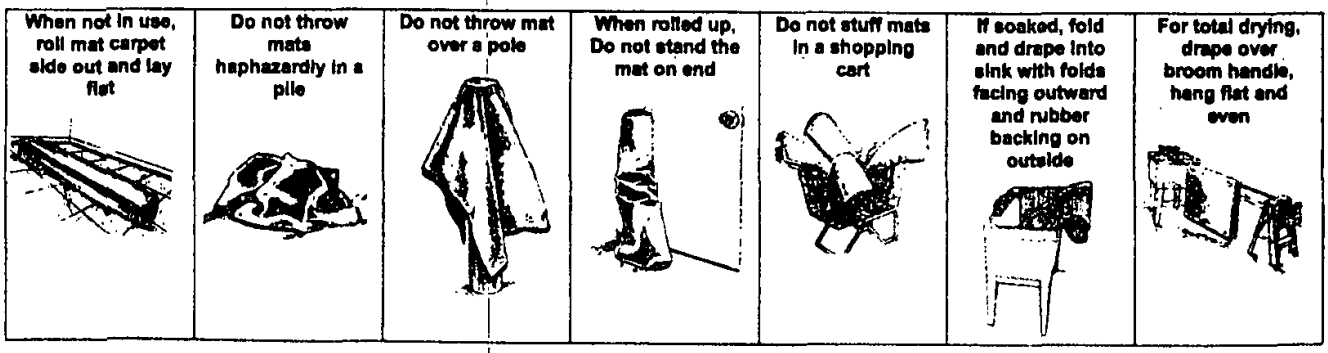

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Voice: 1-800-238-2387
Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
164068	27-Nov-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
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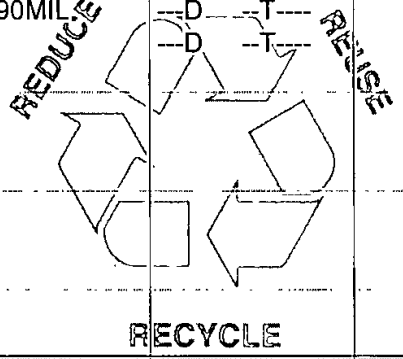
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



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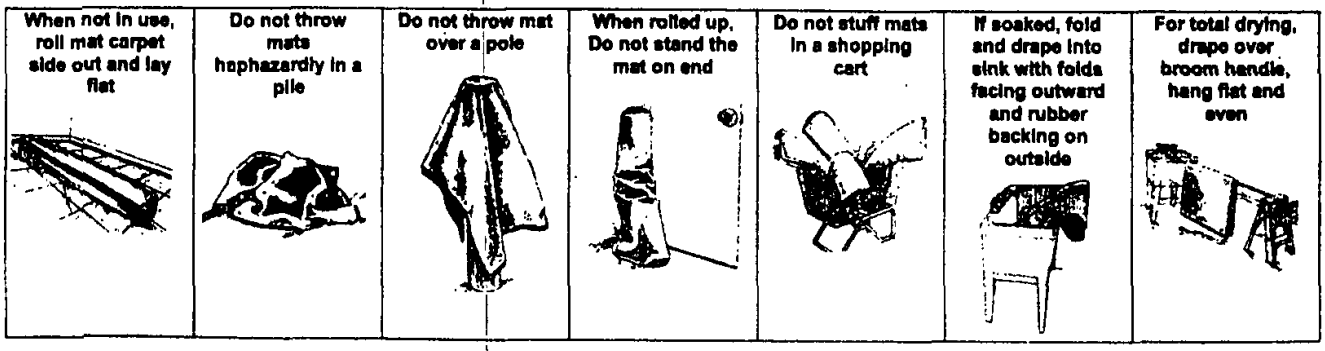
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
167646	25-Dec-2012	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR167423	Charge

SERVICE ADDRESS:

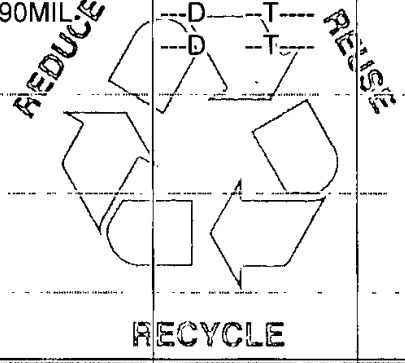
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$139.00	0.00%	0.00	$139.00	$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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CUSTOMER COPY
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TERMS: Net 30 - 2% per month compounded on Overdue Balance.

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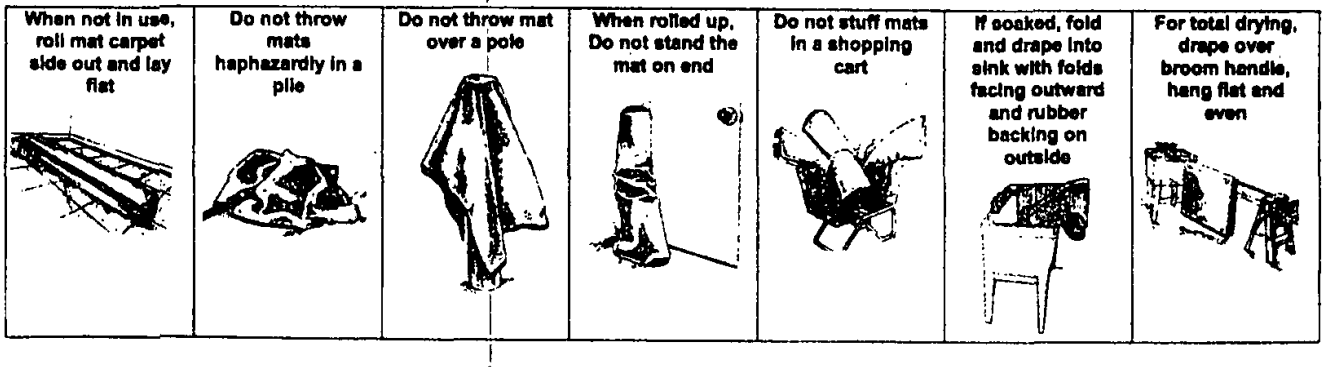

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
171303	22-Jan-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
	Charge

SERVICE ADDRESS:

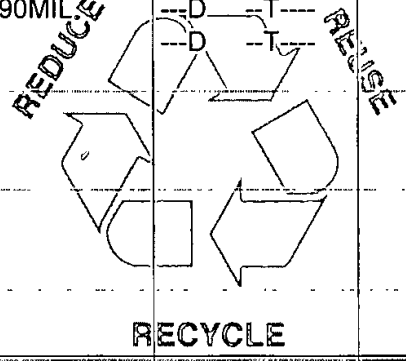
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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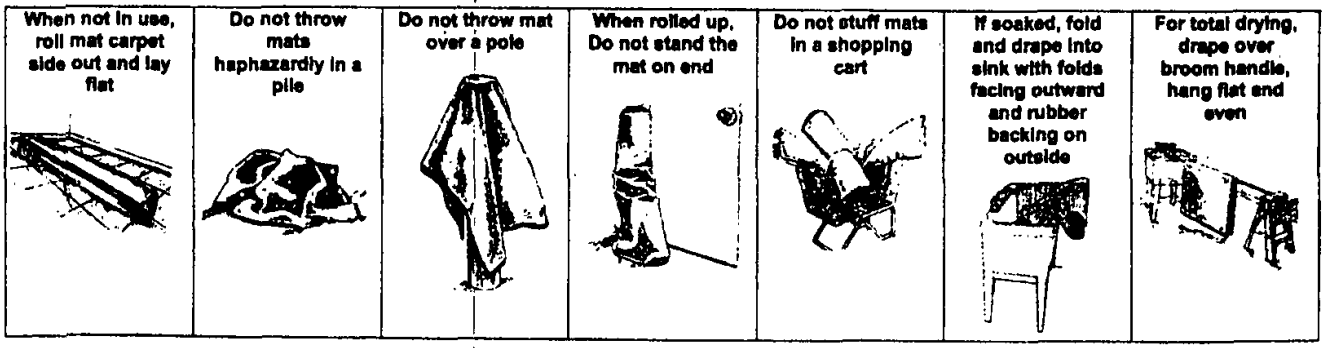

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Middlesex, NJ 08846

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Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No.	Invoice Date	Page
174935	19-Feb-2013	1/1

Customer No.	Route	Key
8091-0	108	1

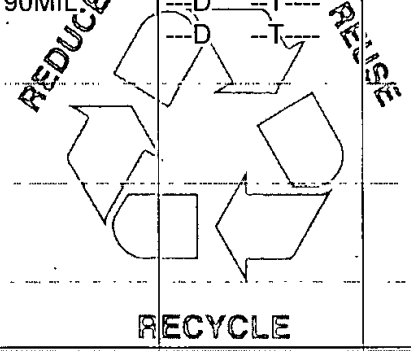
Purchase Order	Terms
	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information
8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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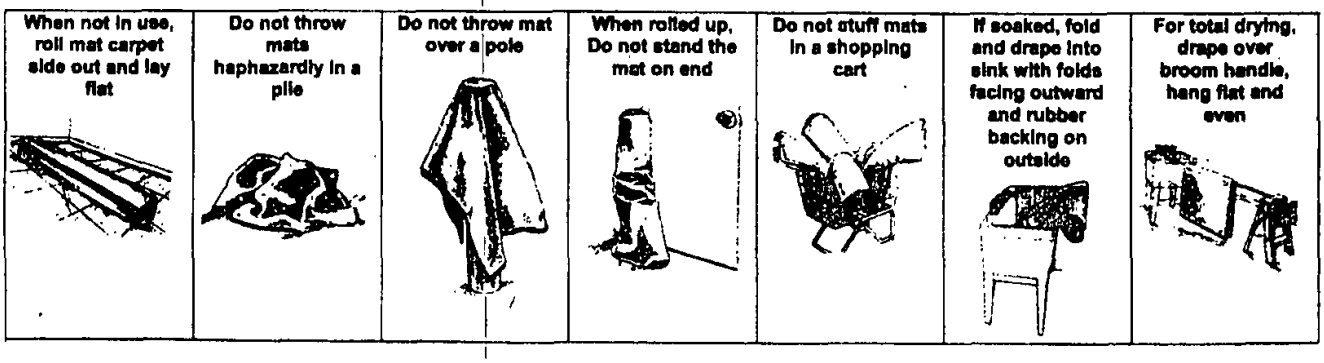

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
178579	19-Mar-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
	Charge

SERVICE ADDRESS:

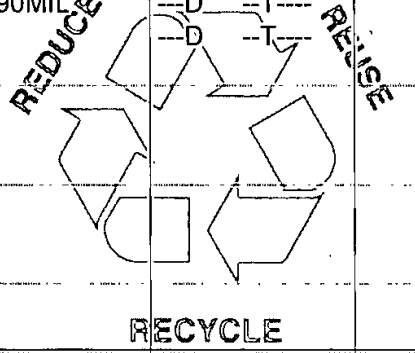
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service	Grand Total
$139.00	0.00%	0.00		$139.00	$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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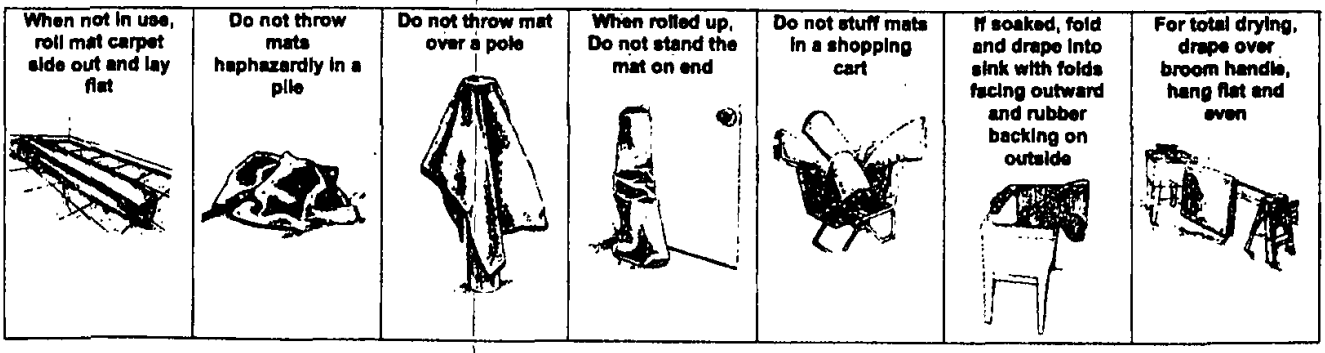

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Middlesex, NJ 08846

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
182183	16-Apr-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939	Charge

SERVICE ADDRESS:

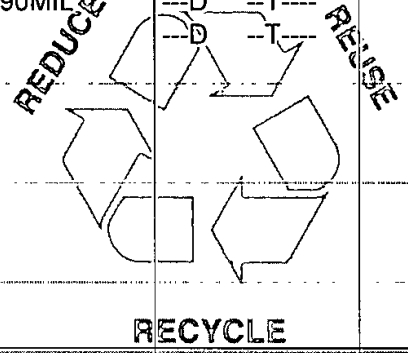
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D --T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D --T----	0	0	*	



Sub Total	NY				This Service		Grand Total
$139.00	0.00%	0.00			$139.00		$139.00

See reverse side for additional company information.

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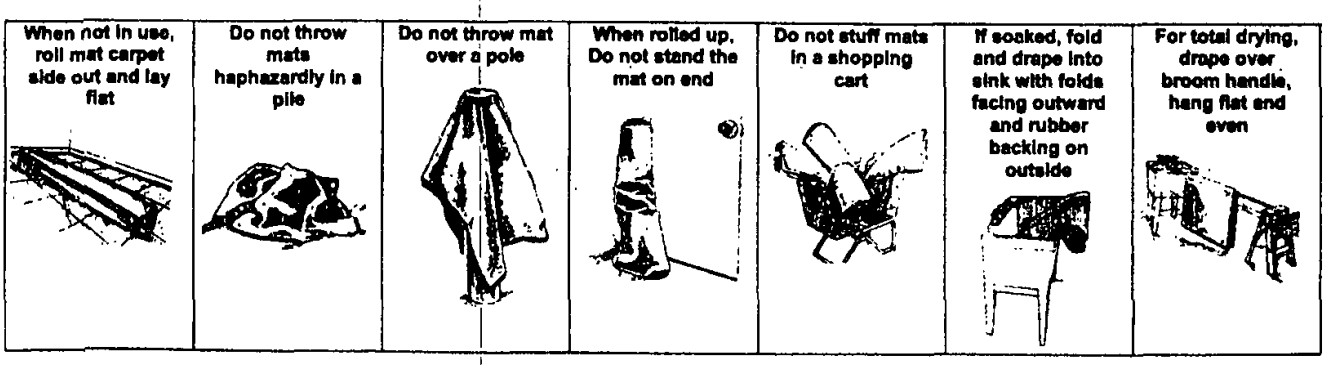

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Invoice No	Invoice Date	Page
185741	14-May-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939	Charge

SERVICE ADDRESS:

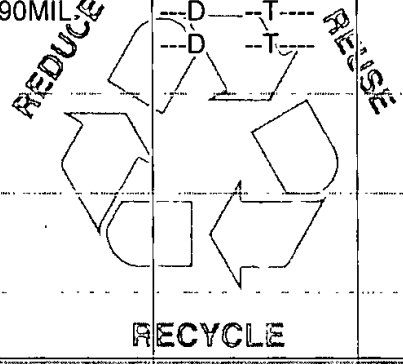
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$139.00	0.00%	0.00	$139.00	$139.00

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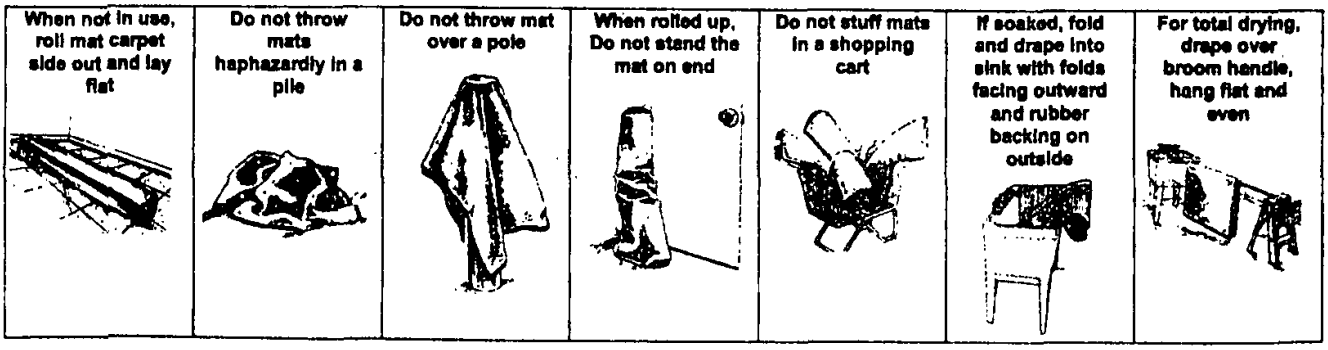

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Invoice No	Invoice Date	Page
189295	11-Jun-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939	Charge

SERVICE ADDRESS:

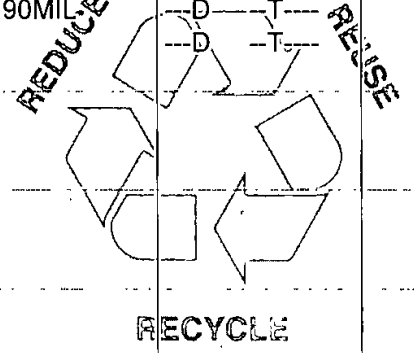
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D----T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$139.00	0.00%	0.00	$139.00	$139.00

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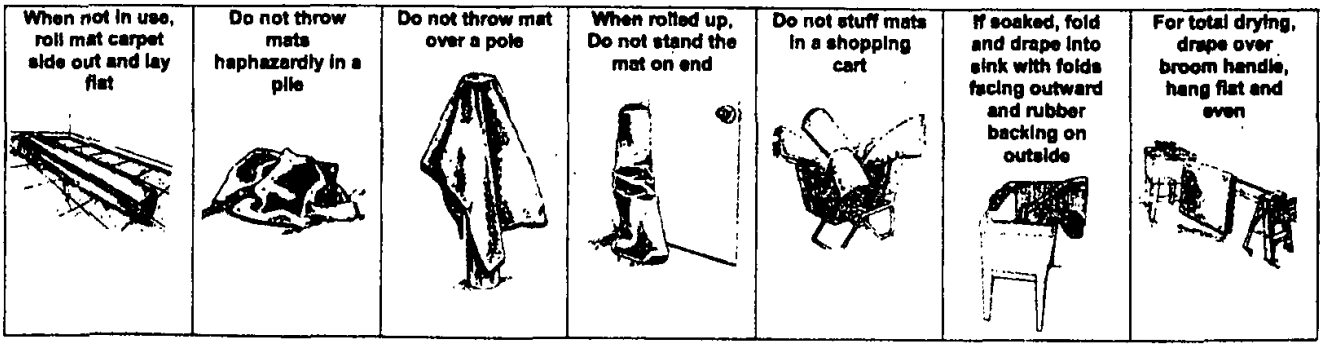

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Invoice No.	Invoice Date	Page
192896	09-Jul-2013	1/1

Customer No.	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939 - NET 30	Charge

SERVICE ADDRESS:

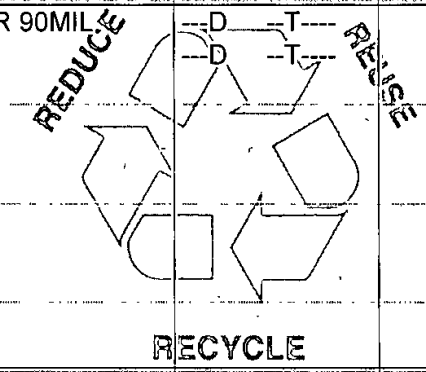
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D----T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D----T----	0	0	*	



Sub Total	NY				This Service		Grand Total
$139.00	0.00%	0.00			$139.00		$139.00

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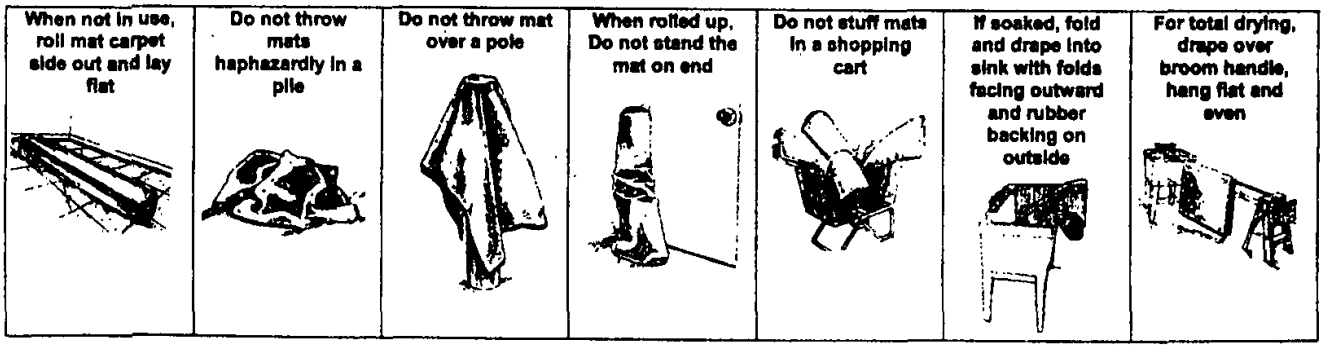
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
196398	06-Aug-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939 - NET 30	Charge

SERVICE ADDRESS:

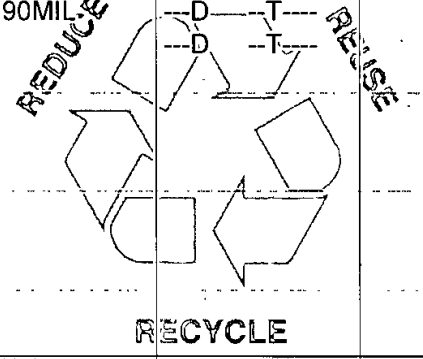
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D----T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D----T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$139.00	0.00%	0.00	$139.00	$139.00

See reverse side for additional company information.

RECEIVED BY: _____

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CUSTOMER COPY

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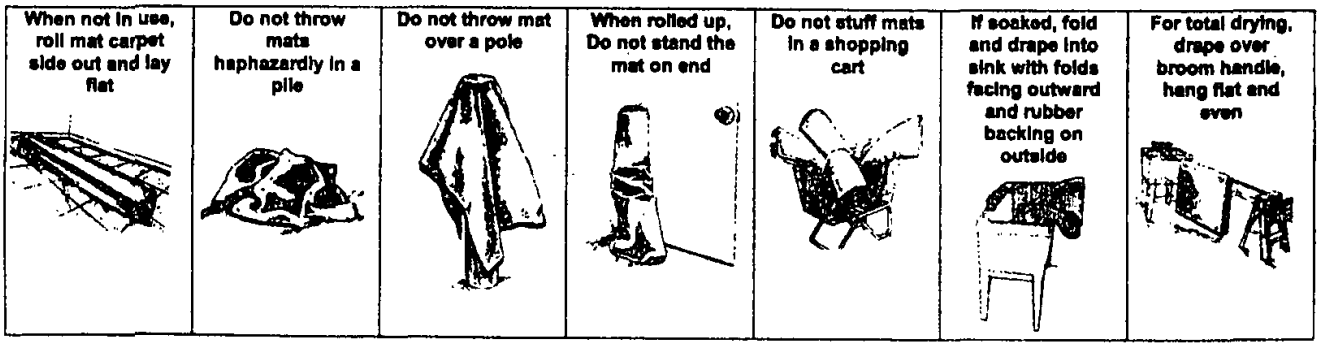


200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No.	Invoice Date	Page
199924	03-Sep-2013	1/1

Customer No.	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939 - NET 30	Charge

SERVICE ADDRESS:

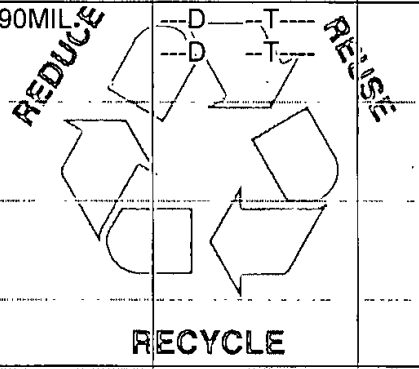
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$139.00	0.00%	0.00	$139.00	$139.00

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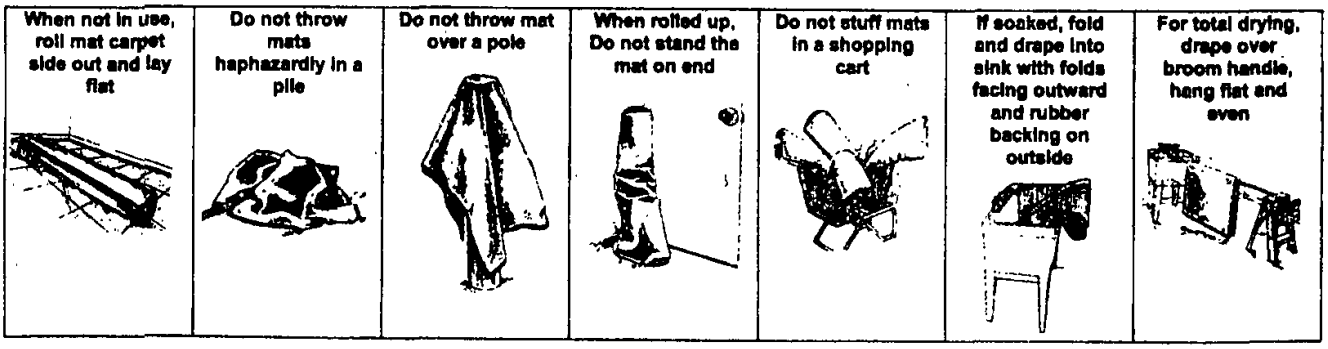


NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No.	Invoice Date	Page
203473	01-Oct-2013	1/1

Customer No	Route	Key
8091-0	108	1

Purchase Order	Terms
NR175939 -	NET 30 Charge

SERVICE ADDRESS:

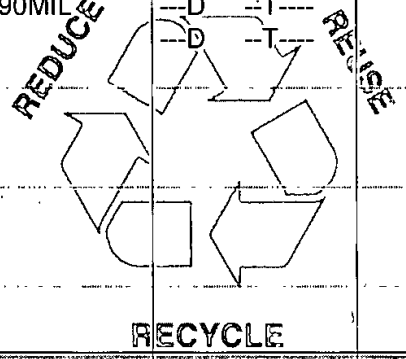
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D---T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$139.00	0.00%	0.00		$139.00		$139.00

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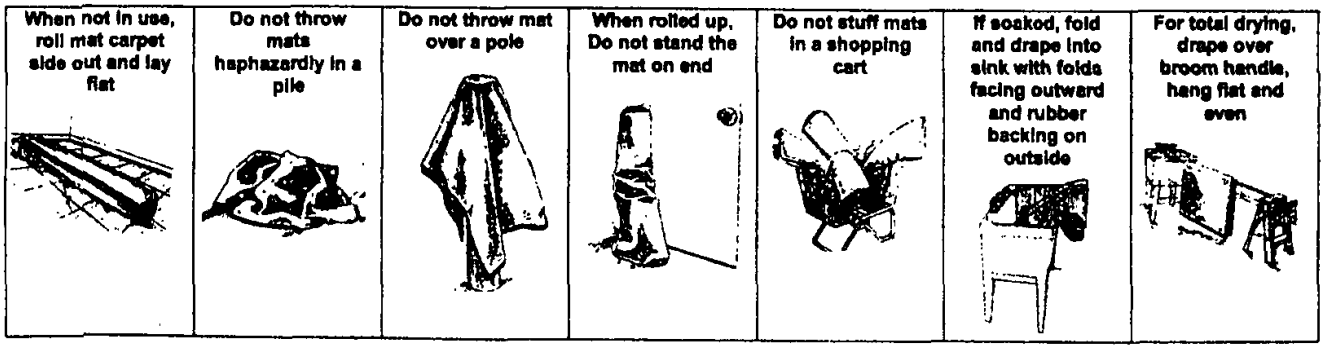


NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
206998	29-Oct-2013	1/1

Customer No:	Route	Key
8091-0	200	1

Purchase Order	Terms
NR175939 - NET 30	Charge

SERVICE ADDRESS:

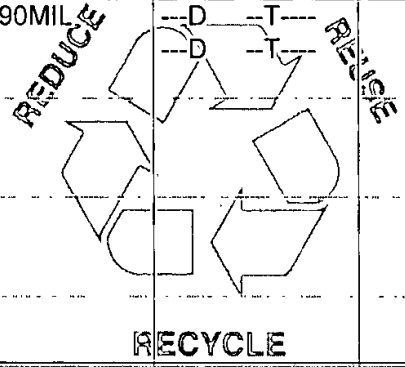
SOUND SHORE MEDICAL CENTER*
16 GUION PLACE
NEW ROCHELLE, NY 10801-

(914) 365-3900

Billing Information

8091-0 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
2	M5X20 CH 90M - 5X20 CH HEATHER 90MIL	---D--T----	2	2	*	
1	X16000 - SERVICE CHARGE	---D--T----	0	0	*	



Sub Total			This Service	Grand Total
$139.00	NY 0.00%	0.00	$139.00	$139.00

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RECEIVED BY: _____

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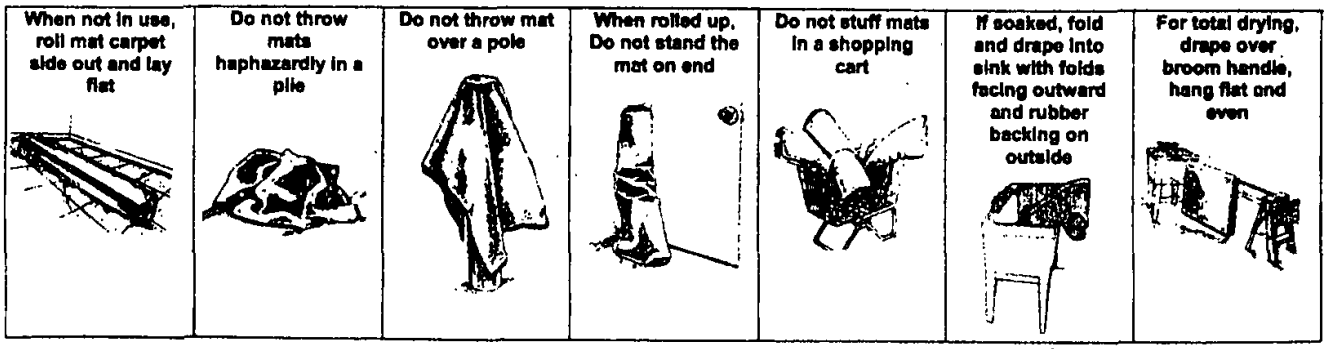

NATIONAL DUST CONTROL
200 Blackford Ave,
Middlesex, NJ 08846
Phone 1-800-238-2387 Fax (732) 748-8888

Statement of Account For:

SOUND SHORE MEDICAL CENTER
ATTN: A/P - HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-

Please Remit To:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Customer Number: 8091-1		Statement Date: 05-Jan-2014			Page 1 of 2
Invoice Date	**Invoice #**	**Service Amt**	**Check No**	**Check Amt**	**Balance**
17-Apr-2012	134790	129.00			129.00
15-May-2012	138484	129.00			129.00
12-Jun-2012	142156	129.00			129.00
10-Jul-2012	145895	129.00			129.00
07-Aug-2012	149520	129.00			129.00
04-Sep-2012	153170	129.00			129.00
02-Oct-2012	156776	129.00			129.00
30-Oct-2012	160382	129.00			129.00
27-Nov-2012	164069	129.00			129.00
25-Dec-2012	167647	129.00			129.00
22-Jan-2013	171304	129.00			129.00
19-Feb-2013	174936	129.00			129.00
19-Mar-2013	178580	129.00			129.00
16-Apr-2013	182184	129.00			129.00
14-May-2013	185742	129.00			129.00

Balance Owing is due on receipt of this statement. Terms: 3% per month compounded.

Current	30-60 Days	60-90 Days	Over 90 Days	Balance Owing

Continued on Page 2

Please tear here and send with your remittance

Remittance advice for: 8091-1

SOUND SHORE MEDICAL CENTER
ATTN: A/P - HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-

As of Date
05-Jan-2014

Invoice #	Balance	☑
134790	129.00	
138484	129.00	
142156	129.00	
145895	129.00	
149520	129.00	
153170	129.00	
156776	129.00	
160382	129.00	
164069	129.00	
167647	129.00	
171304	129.00	
174936	129.00	
178580	129.00	
182184	129.00	
185742	129.00	

Please Remit to:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Please indicate the invoices you are paying by placing a check mark beside the invoice/balance above.

NATIONAL DUST CONTROL
200 Blackford Ave,
Middlesex, NJ 08846
Phone 1-800-238-2387 Fax (732) 748-8888

Statement of Account For:

SOUND SHORE MEDICAL CENTER
ATTN: A/P - HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-

Please Remit To:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

Customer Number: 8091-1 **Statement Date: 05-Jan-2014** **Page 2 of 2**

Invoice Date	Invoice #	Service Amt.	Check No.	Check Amt.	Balance
06-Aug-2013	196399	129.00			129.00
03-Sep-2013	199925	129.00			129.00
01-Oct-2013	203474	129.00			129.00
29-Oct-2013	206999	129.00			129.00

Balance Owing is due on receipt of this statement. Terms: 3% per month compounded.

Current	30-60 Days	60-90 Days	Over 90 Days	Balance Owing
0.00	0.00	129.00	2,322.00	$2,451.00

Please tear here and send with your remittance

Remittance advice for: 8091-1

SOUND SHORE MEDICAL CENTER
ATTN: A/P - HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-

As of Date
05-Jan-2014

Amount Due:
$2,451.00

Amount Enclosed

Invoice #	Balance	☑
196399	129.00	
199925	129.00	
203474	129.00	
206999	129.00	

Please Remit to:

NATIONAL DUST CONTROL
200 BLACKFORD AVE.
MIDDLESEX, NJ 08846-2502
(732) 748-8700

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
134790	17-Apr-2012	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

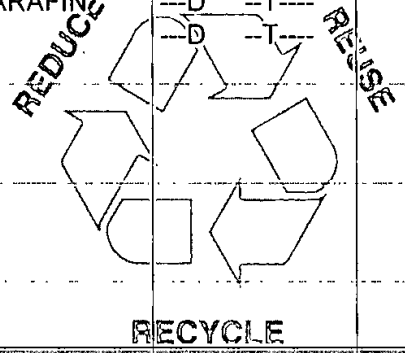
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D --T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D --T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

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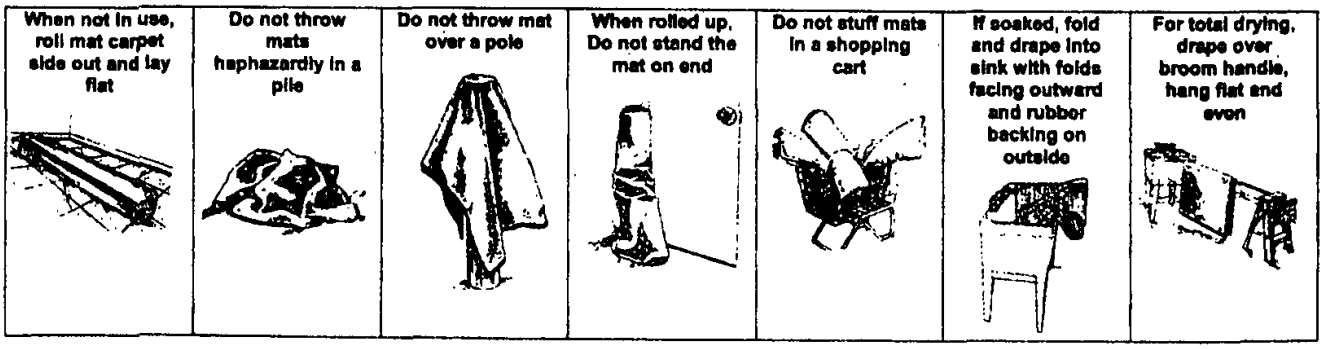


200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
138484	15-May-2012	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

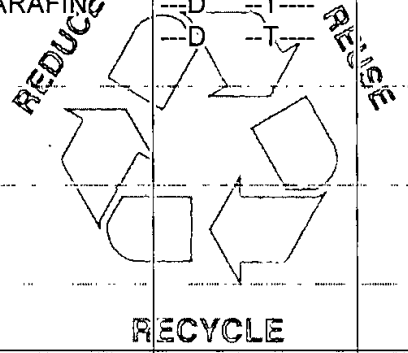
NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



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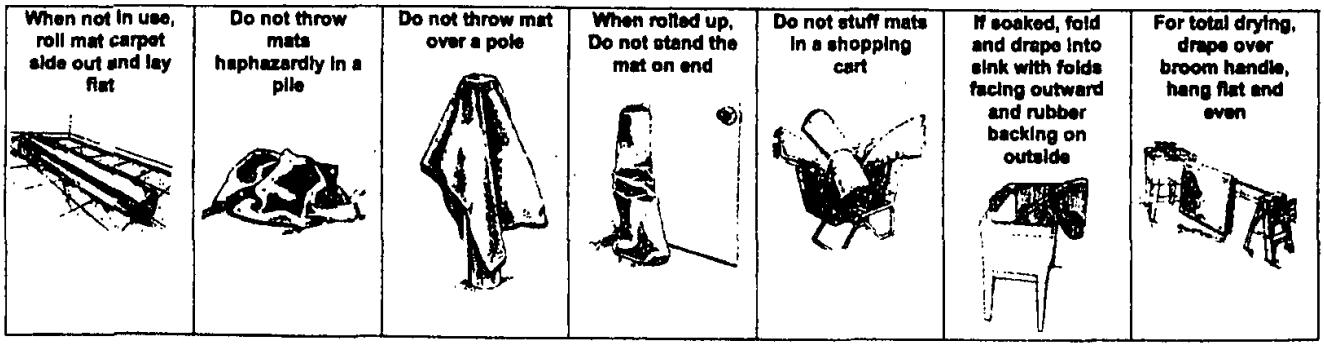
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
142156	12-Jun-2012	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

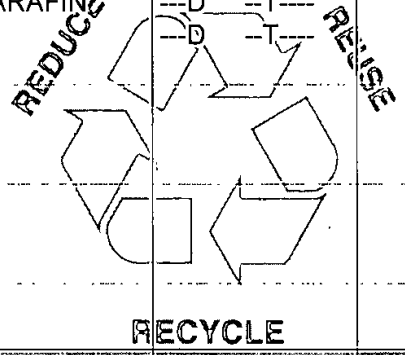
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

See reverse side for additional company information.

RECEIVED BY: _____

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CUSTOMER COPY

DO NOT DESTROY. THIS IS YOUR INVOICE.

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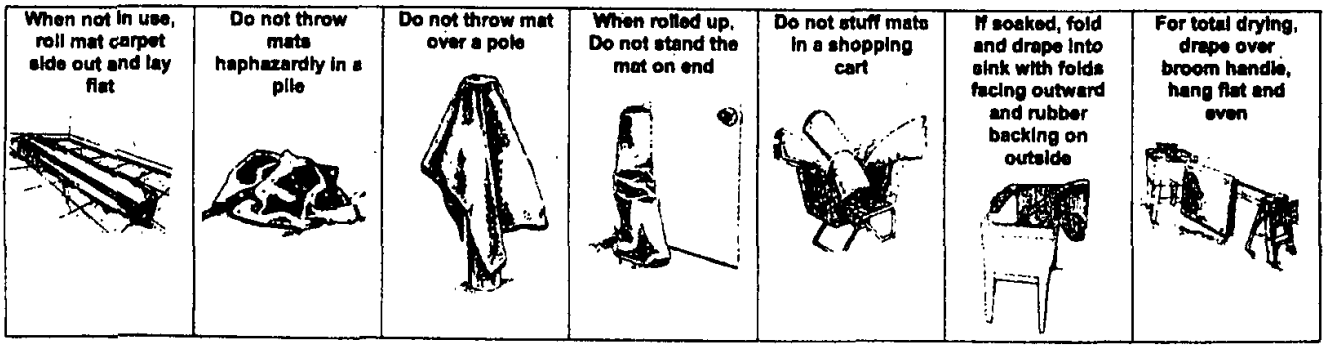

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Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
145895	10-Jul-2012	1/1

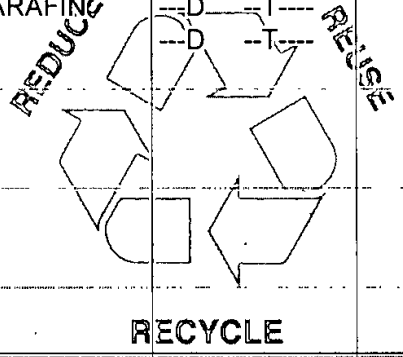
Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

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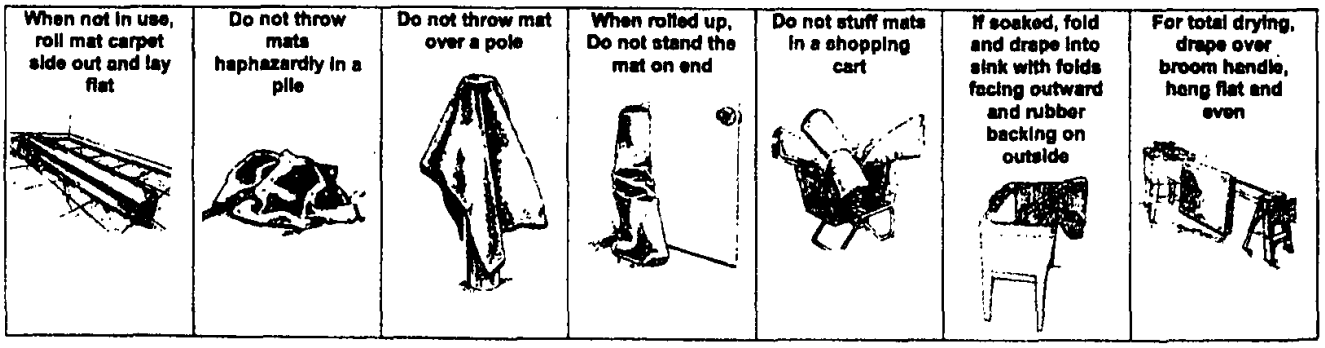

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Middlesex, NJ 08846

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Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
149520	07-Aug-2012	1/1

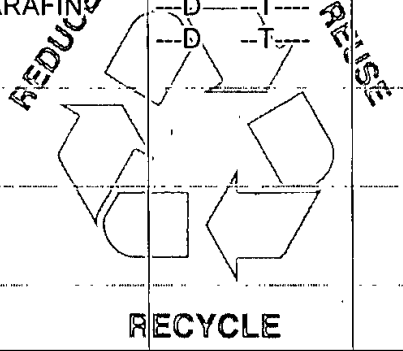
Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D----T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

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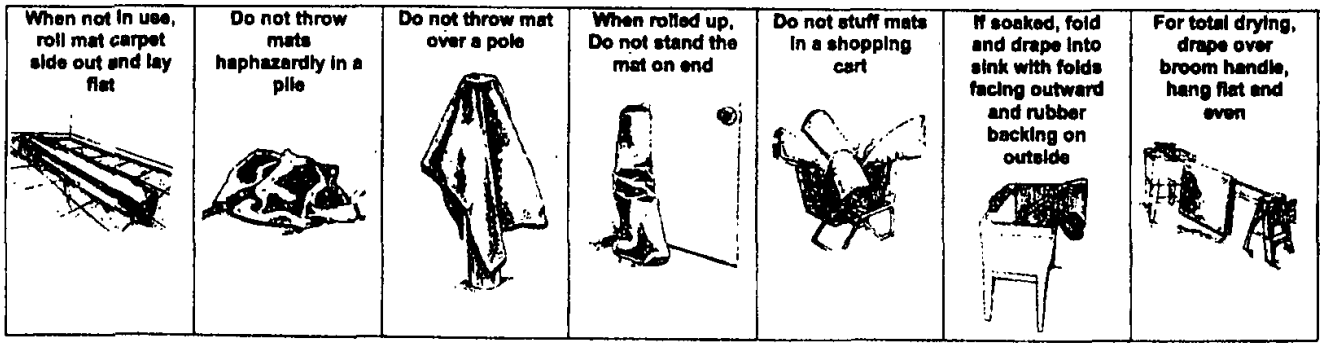

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Middlesex, NJ 08846

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Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
153170	04-Sep-2012	1/1

Customer No	Route	Key
8091-1	108	20

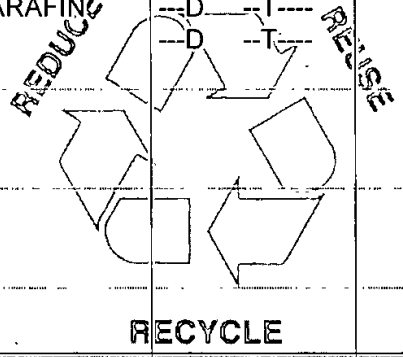
Purchase Order	Terms
NR169788	Charge

SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

RECEIVED BY: _____

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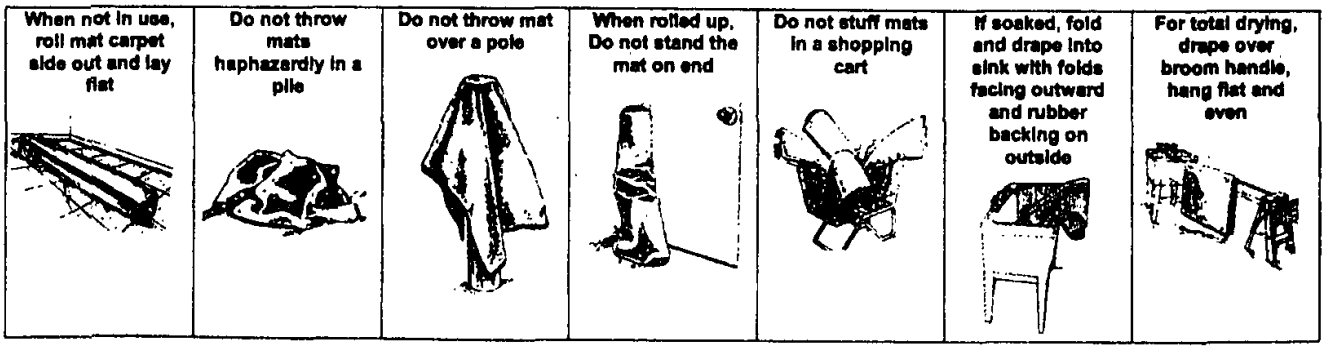

200 Blackford Avenue
Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
156776	02-Oct-2012	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

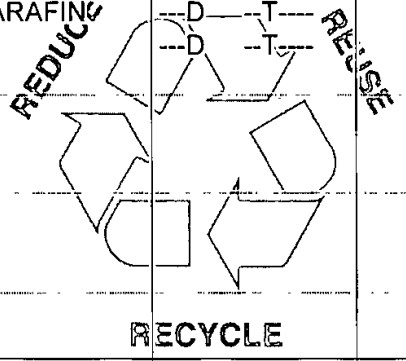
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PARAFIN - 3X10 SCRAPER PARAFIN	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub-Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

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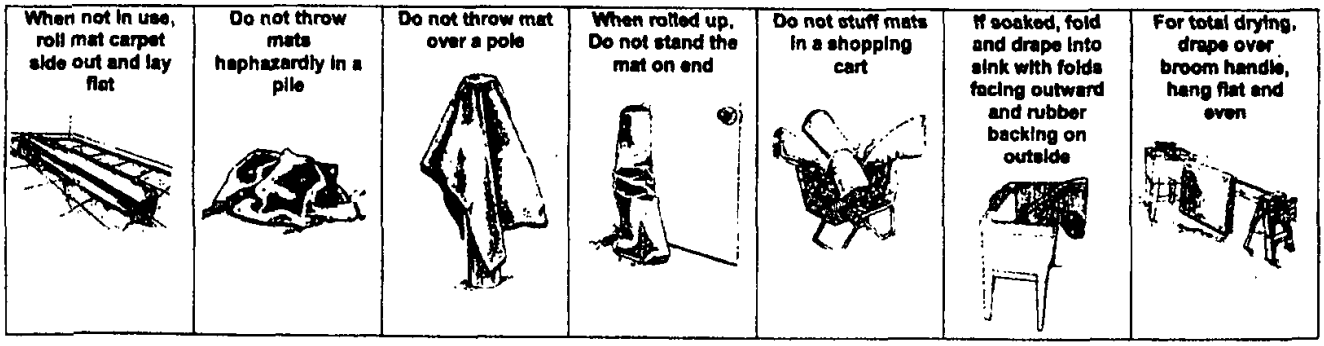

NATIONAL DUST CONTROL
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Middlesex, NJ 08846

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Invoice No.	Invoice Date	Page
160382	30-Oct-2012	1/1

Customer No.	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

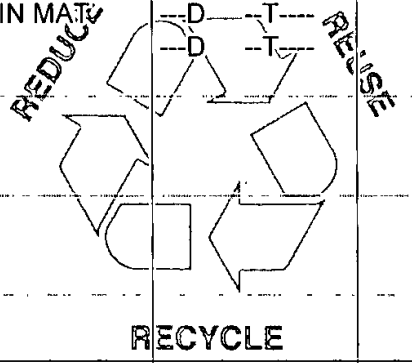
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

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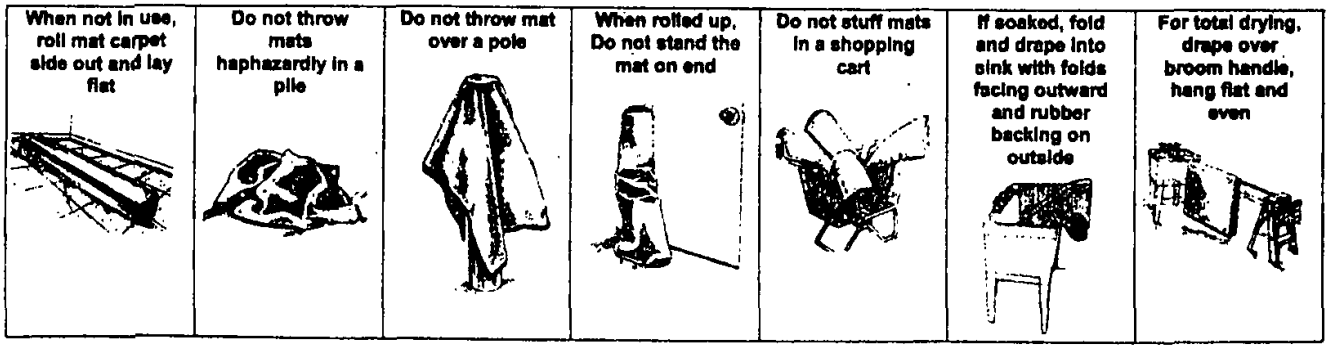

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No.	Invoice Date	Page
164069	27-Nov-2012	1/1

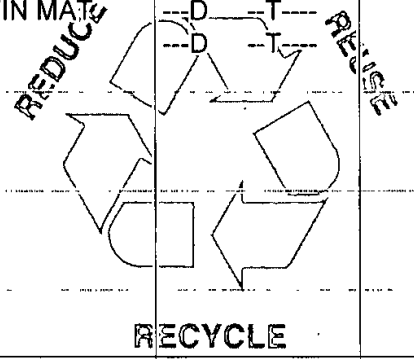
Customer No.	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
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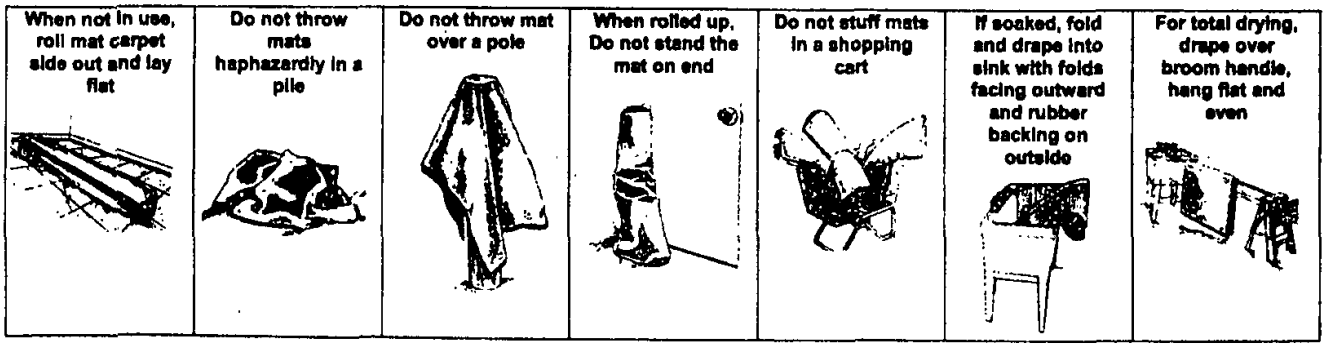

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No.	Invoice Date	Page
167647	25-Dec-2012	1/1

Customer No.	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

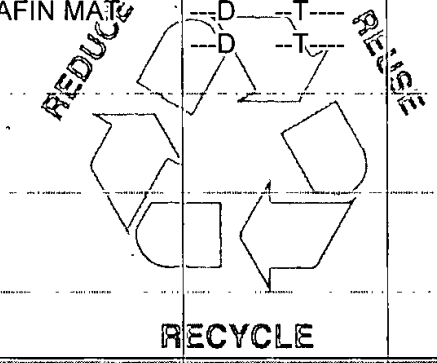
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
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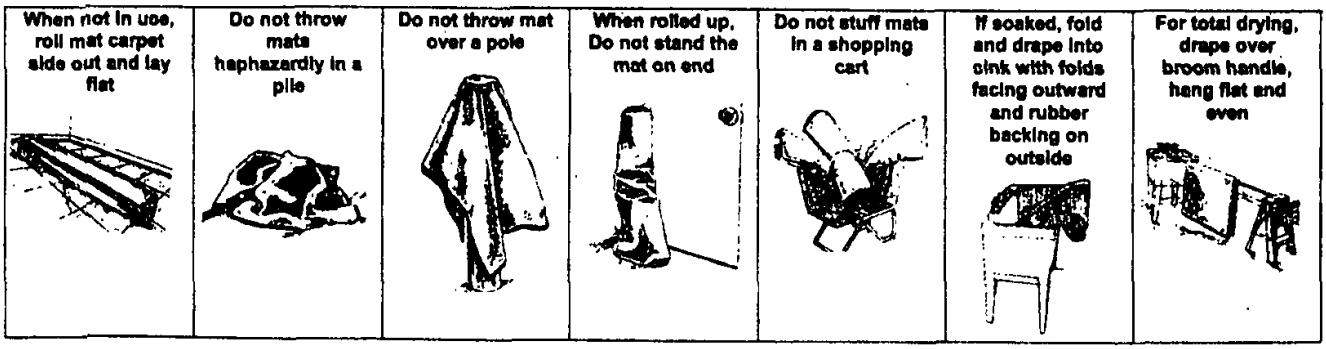
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No.	Invoice Date	Page
171304	22-Jan-2013	1/1

Customer No.	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

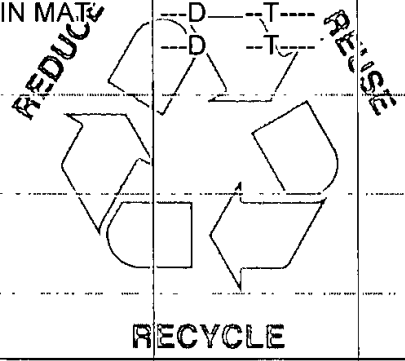
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

See reverse side for additional company information.

RECEIVED BY: _____

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CUSTOMER COPY

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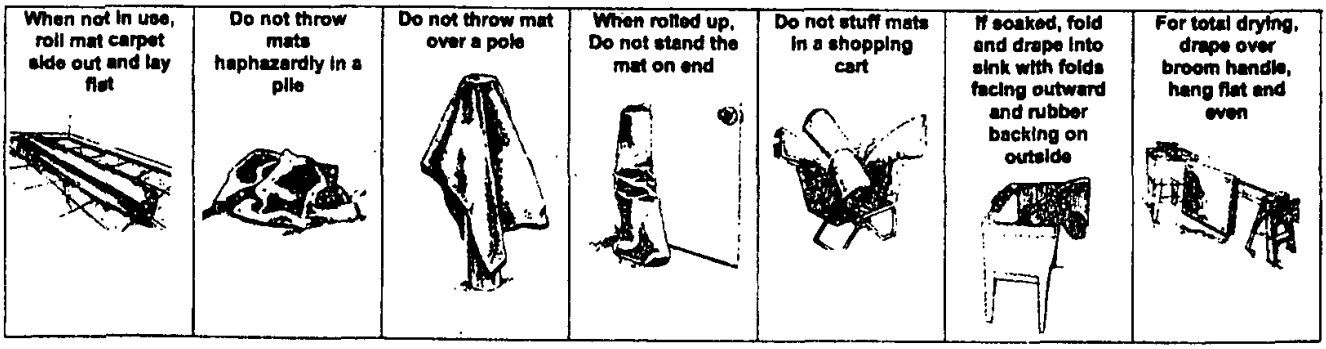

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No	Invoice Date	Page
174936	19-Feb-2013	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

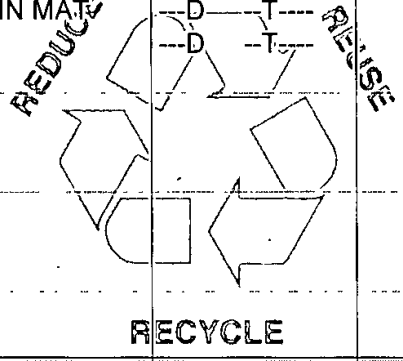
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

RECEIVED BY: _____

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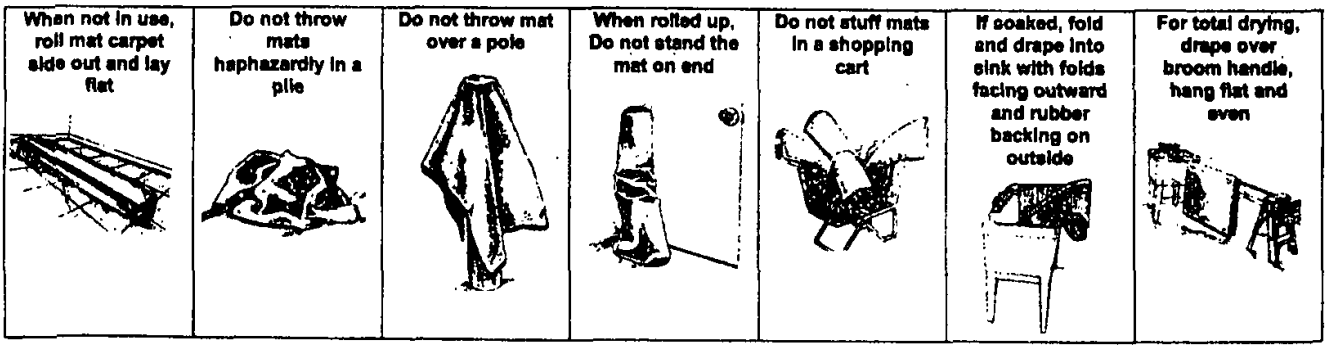

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

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Fax: (732) 748-8888

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Invoice No.	Invoice Date	Page
178580	19-Mar-2013	1/1

Customer No.	Route	Key
8091-1	108	20

Purchase Order	Terms
NR169788	Charge

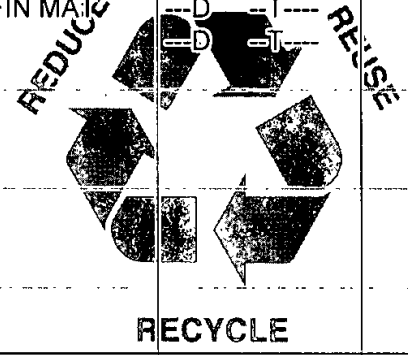
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	UM	Description	Schedule	Pickup	Deliver	Price	Amount
5		M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D ---T----	5	5	*	
1		X16000 - SERVICE CHARGE	---D ---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

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RECEIVED BY: _____

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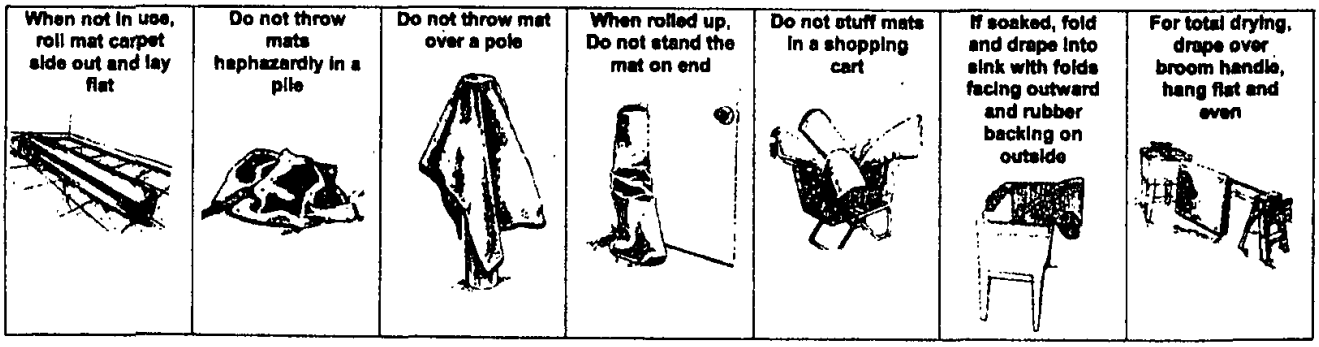

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

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Invoice No.	Invoice Date	Page
182184	16-Apr-2013	1/1

Customer No.	Route	Key
8091-1	108	20

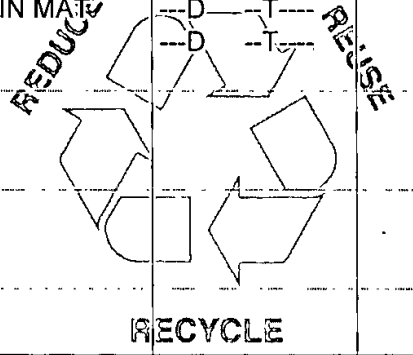
Purchase Order	Terms
NR176052	Charge

SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

RECEIVED BY: _____

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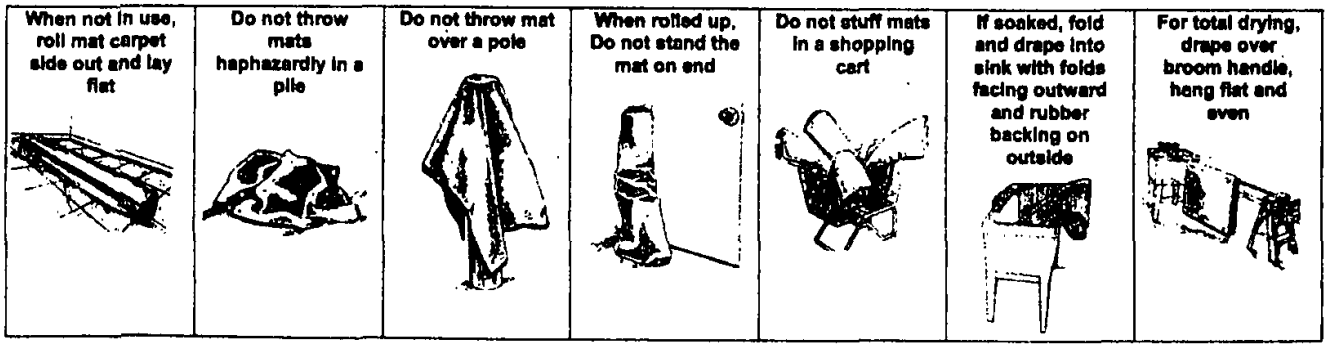

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
185742	14-May-2013	1/1

Customer No	Route	Key
8091-1	108	20

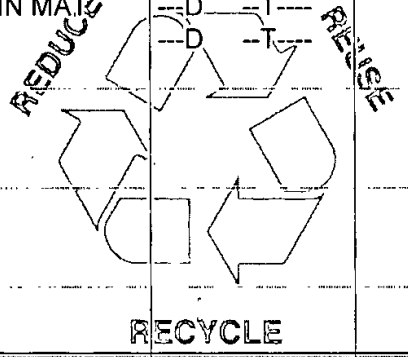
Purchase Order	Terms
NR176052	Charge

SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

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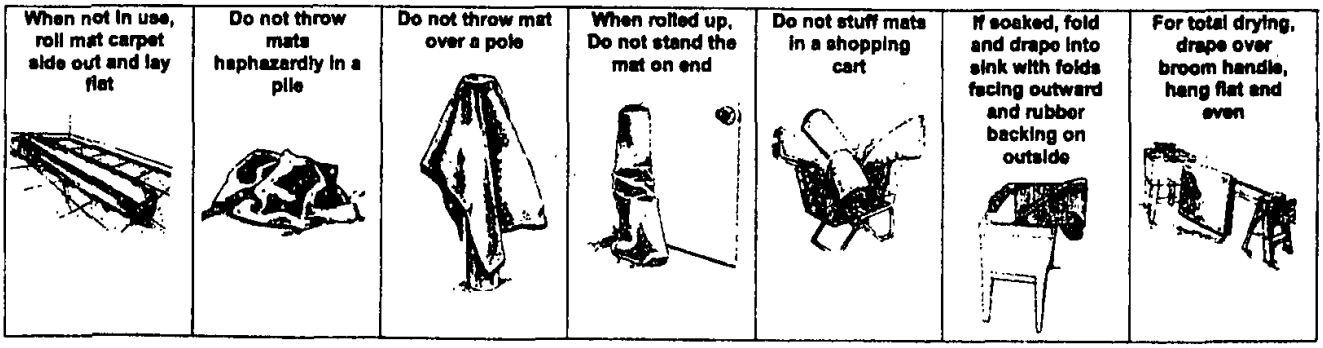

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Middlesex, NJ 08846

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
196399	06-Aug-2013	1/1

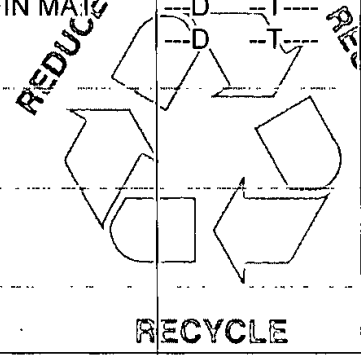
Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR176052 - NET 30	Charge

SERVICE ADDRESS:
SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information
8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
$129.00	0.00%	0.00		$129.00		$129.00

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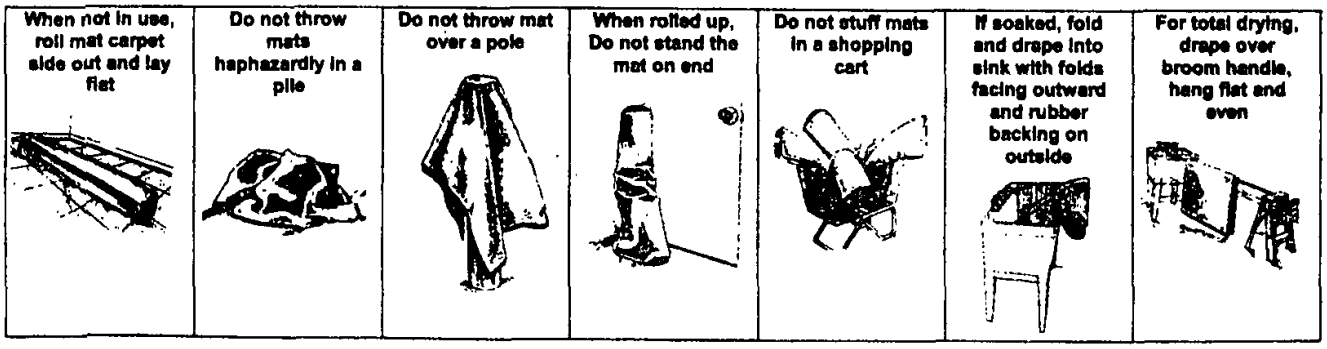

NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

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Invoice No	Invoice Date	Page
199925	03-Sep-2013	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR176052 - NET 30	Charge

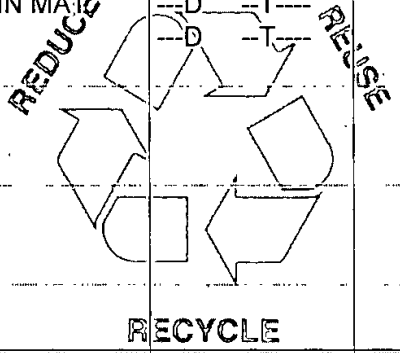
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY			This Service		Grand Total
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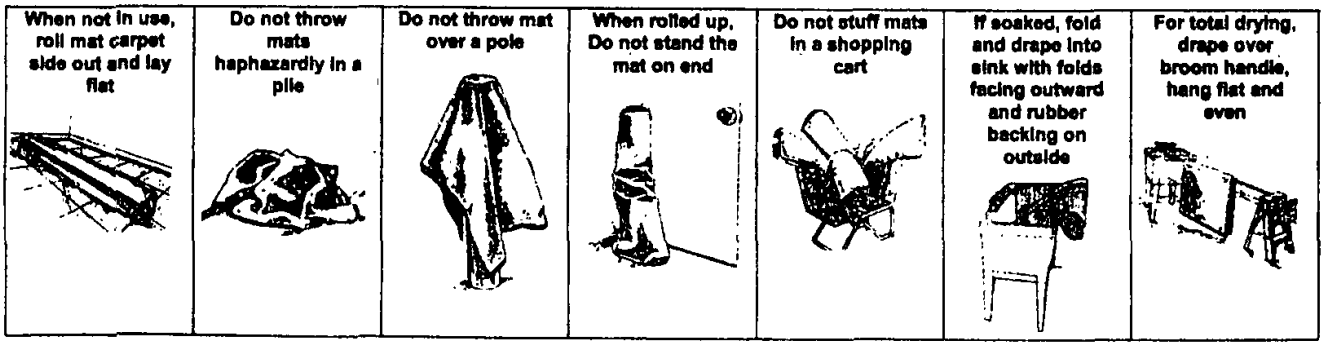

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Fax: (732) 748-8888

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NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

Invoice No	Invoice Date	Page
203474	01-Oct-2013	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR176052 - NET 30	Charge

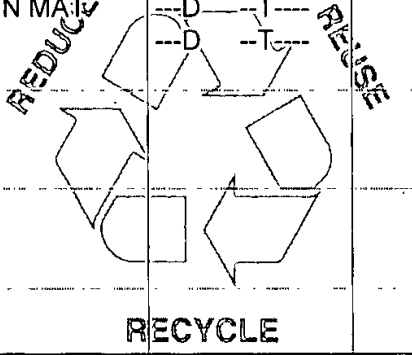
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 SOUND SHORE MEDICAL CENTER

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D----T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D----T----	0	0	*	



Sub Total			This Service	Grand Total
$129.00	NY 0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

RECEIVED BY: _____

All products remain the property of National Dust Control
The above products received in good condition except as noted.
Customer is responsible for loss or damage.

CUSTOMER COPY
DO NOT DESTROY. THIS IS YOUR INVOICE.
TERMS: Net 30 - 2% per month compounded on Overdue Balance.

All items will be cleaned and maintained by National Dust Control (the Company). All items that require replacement due to normal wear will be replaced by the Company at no charge to the Customer.

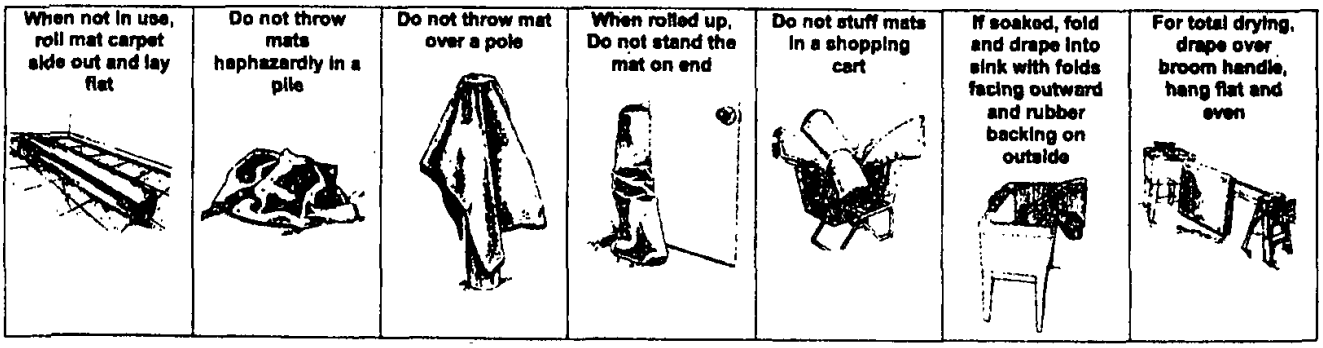
All items remain the property of the Company. In the event items are lost, stolen, or destroyed by fire, acid, paint, gross neglect, or otherwise, the customer will pay for said items at the current replacement value. Customer agrees to notify Company, in writing, of any hazardous materials that may be picked up by Company in the soiled textiles serviced under this agreement. In no case will hazardous materials be present to the extent that they may be harmful to Company's employees.

Customer shall defend and indemnify National Dust Control and hold National Dust Control harmless from and against any and all claims, losses, damages and expenses, including reasonable attorneys' fees and disbursements, resulting from personal injury, bodily injury (including death) and property damage which in any way involves Customer's use of mats rented from National Dust Control, including all claims for product defects and regardless of any action or inaction on the part of National Dust Control.

The company guarantees to deliver the highest quality textile rental service at all times. Any concerns about the quality of our products and services please call our customer service department at 800-238-2387. Company mats are placed in designated areas and should not be moved. If Customer requires any changes to mat placements, mat removals, or mat relocations, Customer must contact Company prior to any such changes.

Customers not currently bound by a service agreement with the Company must give the Company 30 days written notice prior to any cancellations.

INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



NATIONAL DUST CONTROL
QUALITY AND SERVICE SINCE 1970

200 Blackford Avenue
Middlesex, NJ 08846

Voice: 1-800-238-2387
Fax: (732) 748-8888

www.ndcmats.com

Invoice No	Invoice Date	Page
206999	29-Oct-2013	1/1

Customer No	Route	Key
8091-1	108	20

Purchase Order	Terms
NR176052 - NET 30	Charge

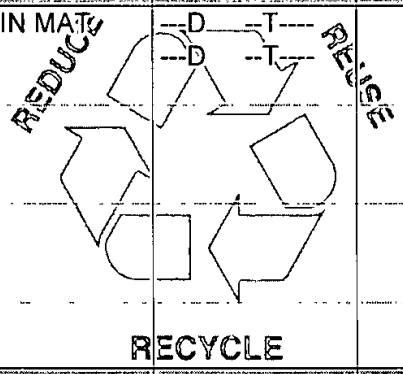
SERVICE ADDRESS:

SOUND SHORE MEDICAL CENTER*
HISTOLOGY LAB
16 GUION PLACE
NEW ROCHELLE, NY 10801-
914 365-3580

Billing Information

8091-1 **SOUND SHORE MEDICAL CENTER**

Qty	Description	Schedule	PickUp	Deliver	Price	Amount
5	M3X10 PAR - 3X10 SCRAPER PARAFIN MAT	---D---T----	5	5	*	
1	X16000 - SERVICE CHARGE	---D---T----	0	0	*	



Sub Total	NY		This Service	Grand Total
$129.00	0.00%	0.00	$129.00	$129.00

See reverse side for additional company information.

RECEIVED BY: _____

All products remain the property of National Dust Control
The above products received in good condition except as noted.
Customer is responsible for loss or damage.

CUSTOMER COPY
DO NOT DESTROY. THIS IS YOUR INVOICE.
TERMS: Net 30 - 2% per month compounded on Overdue Balance.

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All items remain the property of the Company. In the event items are lost, stolen, or destroyed by fire, acid, paint, gross neglect, or otherwise, the customer will pay for said items at the current replacement value. Customer agrees to notify Company, in writing, of any hazardous materials that may be picked up by Company in the soiled textiles serviced under this agreement. In no case will hazardous materials be present to the extent that they may be harmful to Company's employees.

Customer shall defend and indemnify National Dust Control and hold National Dust Control harmless from and against any and all claims, losses, damages and expenses, including reasonable attorneys' fees and disbursements, resulting from personal injury, bodily injury (including death) and property damage which in any way involves Customer's use of mats rented from National Dust Control, including all claims for product defects and regardless of any action or inaction on the part of National Dust Control.

The company guarantees to deliver the highest quality textile rental service at all times. Any concerns about the quality of our products and services please call our customer service department at 800-238-2387. Company mats are placed in designated areas and should not be moved. If Customer requires any changes to mat placements, mat removals, or mat relocations, Customer must contact Company prior to any such changes.

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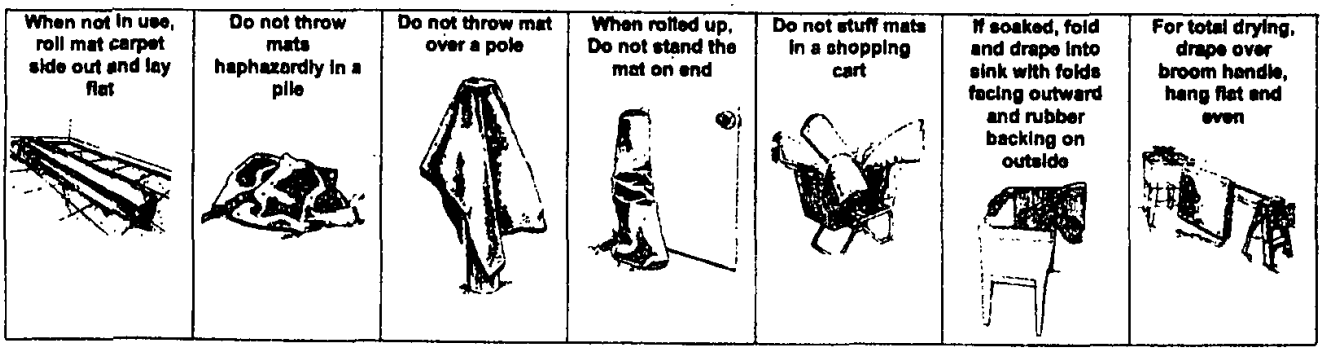
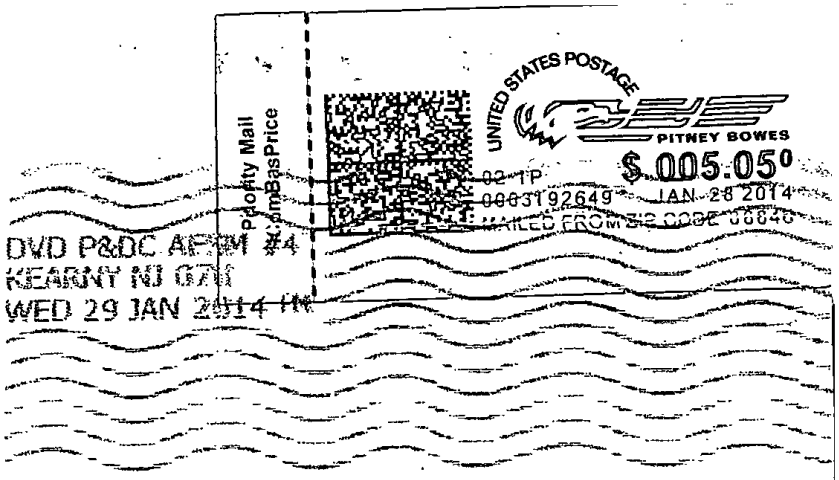
INSTRUCTIONS FOR CARE OF RENTAL FLOOR MATS



13-22840-rdd Doc 1139-10 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 8) Pg 86 of 86

National Dust Control
20 Blackford Ave.
Middlesex, NJ 08846



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

UNITED STATES BANKRUPTCY COURT SOUTHERN DISTRICT OF NEW YORK	**ADMINISTRATIVE EXPENSE PROOF OF CLAIM**	**Administrative Expense Bar Date** January 12, 2015

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)
New York State Office of the Medicaid Inspector General

☐ 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 - 8 2015

Name and Addresses Where Notices Should be Sent:
NYS Attorney General
120 Broadway - 24th Floor
New York, NY 10271
Attn: Enid Nagler Stuart

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: OMIG Medicaid Audit (see attached)

2. DATE DEBT WAS INCURRED (IF KNOWN). September 9, 2014

3. DESCRIPTION OF CLAIM (IF KNOWN): Medicaid overpayments (see attached Draft Audit Report)

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 6,214.71 **(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. Enid Nagler Stuart
Title: Assistant Attorney General
Company: New York State Office of the Attorney General
Address and telephone number (if different from notice address above):

(Signature) (Date) 1/6/15

Telephone number. _____ email: Enid.Stuart@ag.ny.gov

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 - 01534
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

ERIC T. SCHNEIDERMAN
ATTORNEY GENERAL

KENT T. STAUFFER
EXECUTIVE DEPUTY ATTORNEY GENERAL
DIVISION OF STATE COUNSEL

LISA R. DELL
ASSISTANT ATTORNEY GENERAL IN CHARGE
LITIGATION BUREAU

WRITER'S TELEPHONE (212) 416-8666

January 7, 2015

BY UPS

Sound Shore Medical Center
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, Ohio 43017

Re: In Re The Mount Vernon Hospital, Inc.,
Case #13-22841-RDD

Dear Sir or Madam:

Enclosed are an original and a copy of an administrative Proof of Claim to be filed in the above-referenced case. Please file the original and date-stamp and return the copy in the self-addressed and stamped envelope provided for your convenience.

Thank you for your attention to this matter.

Very truly yours,

Enid Nagler Stuart
Assistant Attorney General

Enc.

In re Sound Shore Medical Center of Westchester, et. Al.
Debtor: The Mount Vernon Hospital, Inc.

LIST OF CLAIMS

PROJECT #	AUDIT PERIOD	AMOUNT
1. 2014Z01-100Q	Jan. 1, 2010- June 30, 2013	$6,214.71
(Six thousand, two hundred fourteen dollars and seventy-one cents)		
TOTAL CLAIMS		**$ 6,214.71**

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

September 9, 2014

Kathyleen McKay, Assistant VP, HR & Compliance Officer
Mount Vernon Hospital
16 Guion Place
New Rochelle, New York 10802

DRAFT AUDIT REPORT
Audit #2014Z01-100Q
Provider #00274117

Dear Ms. McKay:

The New York State Office of the Medicaid Inspector General (the "OMIG") performed an audit of Medicaid clinic and emergency room claims for Medicaid recipients who were inpatients at the hospital affiliated with the outpatient providers. In addition, an audit of Medicaid ancillary services claims for Medicaid recipients who were an inpatient in a hospital on the date of service was also performed. In accordance with Section 517.5 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this report represents the preliminary determination on issues found during the OMIG's review.

BACKGROUND, PURPOSE AND SCOPE

The New York State Department of Health (DOH) is responsible for the administration of the Medicaid program. As an independent office within DOH, the OMIG conducts audits and reviews of providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in NY Public Health Law, NY Social Services Law, regulations of the Department of Health, (Titles 10 and 18 of the NYCRR), Medicaid Provider Manuals, and *Medicaid Update* publications.

Under Section 86-1.18 of Title 10 of the New York Codes, Rules and Regulations, the Department of Health establishes all-inclusive hospital inpatient rates that cover the costs of almost all services provided to Medicaid recipients who are hospitalized. Additionally, the EMedNY Provider Manual for Clinics specifically prohibits separate emergency room and clinic billing during a recipient's inpatient hospital stay.

During a Medicaid recipient's hospital stay, the inpatient DRG based rate is a generally all-inclusive rate and there should be no emergency room or clinic billings by the hospital for that patient. In addition, no clinic or emergency room visit is to be billed if the patient is subsequently admitted that same day to the hospital.

The purpose of this audit is to identify Medicaid provider claims for either clinic or emergency room services, billed during a Medicaid patient's inpatient stay, excluding date of discharge. To accomplish this, claims submitted for clinic and/or emergency room services with payment dates from July 1, 2011 through June 30, 2013 were reviewed. Claims on the last day of an inpatient hospital stay were excluded from the audit.

In addition, this audit identified potential Medicaid overpayments made to you for laboratory and/or other ordered ambulatory services provided to Medicaid patients, who on the same date as these services, received inpatient services at a hospital. When Medicaid pays for such outpatient service for a hospitalized recipient, it is paying twice for the same service: first when it pays the inpatient rate and again when it pays the outpatient provider's separate claim. Inpatient hospital rates include all the costs incurred for the care of inpatients. To accomplish this, laboratory and/or ordered ambulatory service claims with payment dates from January 1, 2010 through June 30, 2013 were reviewed. Certain dates of hospital admission were excluded from this report. All dates of discharge were excluded from this report.

Please note that due to the implementation of the National Provider Identifier (NPI) on September 1, 2008, there may be multiple Provider Identification Numbers associated with the Primary Provider Identification Number. The NPI is linked to the Primary Provider Identification Number. The Primary Provider Identification Number is used for correspondence and recoupment.

DETAILED FINDINGS

The exhibits are detailed in three categories. All or a combination of the following three exhibits are included in this Draft Audit Report.

1. **Clinic and Emergency Room Outpatient Visits Billed On the Same Day as a Hospital Inpatient Stay**

   Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

   18 NYCRR §504.3(h)

   Regulations state: "By enrolling the provider agrees ... to comply with the rules, regulations and official directives of the department."

   18 NYCRR §504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the result of ...improper claiming, unacceptable practices, fraud, abuse or mistake" and provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c)

The EMedNY Provider Manual for Inpatient states: "If a patient is seen in the hospital's emergency room or outpatient clinic and is subsequently admitted to the hospital on the same day, Medicaid reimbursement will be limited to the hospital's inpatient rate. The hospital may not bill for the emergency room or clinic services provided on the day of admission."

EMedNY Provider Manual for Inpatient Policy Guidelines
Version 2007-1 (effective 25 May 2007), p.18 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 20 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 19 of 27.

The EMedNY Provider Manual for Clinic states: "When a Medicaid-eligible patient is admitted as an inpatient on the same day as a clinic or emergency room visit, payment can be claimed only for the inpatient cost per discharge. Payment to the hospital under diagnosis related groups (DRGs) or per diems is payment in full. No emergency room or clinic services may be billed to Medicaid during the Medicaid eligible patient's inpatient stay, i.e., billing additionally for an MRI while a patient is hospitalized."

EMedNY Provider Manual for Clinic
Version 2007-2 (effective 01 June 2007) p. 4 of 42.

Exhibit 1 is a list of all claims that contain clinic and emergency room services billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $1,438.91.

2. <u>Laboratory Services Billed Fee for Service that are Included in the Inpatient Rate</u>

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the result of ...improper claiming, unacceptable practices, fraud, abuse or mistake" and provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c)

Regulations state: "No payment will be made on a fee-for-service basis for laboratory services ordered for an MA recipient on either an in-patient or out-patient basis when the cost of providing laboratory services has been included in the MA rate of payment for the provider of such in-patient or out-patient care."

18 NYCRR 505.7(g)(7)

The EMedNY Provider Manual for Laboratory states: "Medicaid payment rates for hospital inpatient stays include all laboratory tests provided to hospital inpatients. Accordingly, no laboratory procedures rendered to hospital inpatients are authorized to be billed separately to Medicaid on a fee-for-service basis."

EMedNY Provider Manual for Laboratory Policy Guidelines
Version 2005-1 (effective 01 Jan 2005), p.13 of 24;
Version 2011-1 (effective 06 Sept 2011), p.15 of 27.

The EMedNY Provider Manual for Inpatient states: "Billing on a fee-for-service basis for tests already included in a facilities rate structure is considered to be a duplicate payment and, as such, will be recouped by Medicaid."

EMedNY Provider Manual for Inpatient Policy Guidelines
Version 2007-1 (effective 25 May 2007), p.15 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 17 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 16 of 27.

"The EMedNY Provider Manual for Inpatient states: Medicaid patients are provided a full range of necessary diagnostic, palliative, and therapeutic inpatient hospital care, including but not limited to surgical, medical, nursing, radiological, laboratory, and rehabilitative services."

EMedNY Provider Manual for Inpatient Policy Guidelines
Version 2007-1 (effective 25 May 2007), p.9 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 11 of 30;
Version 2012-1 (effective 21 Nov 2012), p. 10 of 27.

Exhibit 2 is a list of all claims that contain laboratory services billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $3,029.96.

3. <u>Ordered Ambulatory Services (Other Than Labs) Billed Fee for Service that are Included in the Inpatient Rate</u>

Regulations state: "By enrolling the provider agrees ... that the information provided in relation to any claim for payment shall be true, accurate, and complete;"

18 NYCRR 504.3(h)

Regulations state: "By enrolling, the provider agrees... to comply with the rules, regulations and official directives of the department."

18 NYCRR 504.3(i)

Regulation 18 NYCRR 518.1(c) defines "overpayment" as "any amount not authorized to be paid under the medical assistance program, whether paid as the result of ...improper claiming, unacceptable practices, fraud, abuse or mistake" and provides for the recovery by OMIG of these overpayments.

18 NYCRR 518.1(c)

The DOH Medicaid Update states: "Ancillary services that are already included in a facility's all inclusive DRG payment... should not be billed on a fee-for-service basis. Services rendered to hospital inpatients should not be billed on an ordered ambulatory basis. This situation is considered to be a duplicate payment and therefore subject to recoupment."

DOH Medicaid Update July 2008 Vol. 24, No.8
Hospital, Laboratory, & Ambulatory Care Providers

The EMedNY Provider Manual for Inpatient states: "The Medicaid payment for inpatient care is considered to include all procedures and services regardless of where they were performed.

The original hospital is responsible for reimbursing all other hospitals; clinics or ambulatory surgery centers which provide the services not available at the admitting hospital."

EMedNY Provider Manual for Inpatient Policy Guidelines
Version 2007-1 (effective 25 May 2007), p.15 of 26;
Version 2011-1 (effective 05 Dec 2011), p. 18 of 30;
Version 2012-1 (effective 21 Nov 2012), p.16 of 27.

Exhibit 3 is a list of all claims that contain ordered ambulatory services (other than labs) billed to Medicaid during a Medicaid patient's inpatient hospital stay. These services must be billed to the original admitting hospital. Submitting these claims to Medicaid resulted in an overpayment of $1,210.79.

DETERMINATION

In accordance with 18 NYCRR §518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the date of the overpayment. The OMIG has preliminarily determined that accrued interest for the overpayments identified in this audit total $535.05.

Based on this, the total amount of overpayment, as defined in 18 NYCRR §518.1 is $6,214.71, inclusive of interest and now due the New York State Department of Health.

Do not submit claim voids or adjustments in response to this Draft Audit Report. The Final Audit Report will include repayment instructions.

PROVIDER RIGHTS

You may submit written arguments and documentation objecting to these determinations and proposed actions within 30 days of receiving this Draft Audit Report. Receipt is presumed to be 5 days after the date of the Draft Audit Report. All written arguments and documents should be submitted to:

Ottavio Nicotina
Audit #2014Z01-100Q
Office of the Medicaid Inspector General
Bureau of Payment Controls and Monitoring
800 North Pearl Street
Albany, New York 12204

Your objections must include a written statement detailing the specific items in the Draft Audit Report to which you object. After a review of your arguments and documentation, the OMIG will notify you of the final determination. If no arguments and/or documentation in objection to the determination and proposed action are received in the time set forth herein, OMIG may adopt the actions proposed above as its final action. If the final determination or action is adverse to your interest, you will be given further appeal rights, including the right to request an administrative hearing to review the final determination. Pursuant to 18 NYCRR § 519.18, the issues to be addressed in any such hearing will be limited to the factual or legal matters contained in your response to this Notice.

OMIG reserves the right to conduct further reviews of your participation in the Medicaid Program and to take other administrative or legal action where appropriate, and recover any Medicaid overpayments through the initiation of a set-off or withholding of payments, a civil lawsuit or any other lawful means.

Do not submit claim voids in response to this Draft Audit Report. The final audit report will include repayment instructions.

To obtain the password for the enclosed disc, please email Ottavio.Nicotina@OMIG.NY.GOV. Questions regarding this audit may be directed to Ottavio Nicotina at (518) 402-1467. or by fax at (518) 486-7192.

Sincerely,

Sandra Noonan, Manager
System Match and Recovery
Office of the Medicaid Inspector General

Enclosure
CERTIFIED MAIL
RETURN RECEIPT REQUESTED

13-22840-rdd Doc 1139-11 Filed 06/29/15 Entered 06/29/15 11:51:16 Claims
(Part 9) Pg 10 of 39

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☐ EXPRESS (INT'L)
☐ DOCUMENTS ONLY
☐

The shipper authorizes UPS to act as forwarding agent for export control and customs purposes. The shipper certifies that these commodities, technology or software were exported from the United States in accordance with the Export Administration Regulations. Diversion contrary to U.S. law is prohibited.

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REFERENCE NUMBER

1Z 144 770 22 1068 9268

1Z 144 770 22 1068 9268 EXPORT

TELEPHONE 212-416-8813 x1966

Enid Nagler Stuart
NYS OFF. ATTORNEY GENERAL
120 BROADWAY FLR 4
NEW YORK NY 10271

UPS Next Day Air® 1

DELIVERY TO

TELEPHONE

Sound Shore Medical Center
c/o GCG, Inc.
5151 Blazer Parkway, Suite A
Dublin, Ohio 43017

Residential ☐

1Z 144 770 22 1068 9268 DELIVERY

1Z 144 770 22 1068 9268
TRACKING NUMBER

DATE OF SHIPMENT / /

SHIPMENT ID NUMBER 1447 707F VCM

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United Parcel Service, Louisville, KY

292 of 1000 19985585 012

5151 BLAZER PKWY
DUBLIN OH 43017

P: MBKM3 S: MG I: 302
CATT – 1019
1Z144770221068 9268 1030

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	**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)
OCEANSIDE Institutional Industries, 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.

THE GARDEN CITY GROUP, INC. FEB - 1 2014

Name and Addresses Where Notices Should be Sent:
2525 Long Beach Road
Oceanside, NY 11572

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): 11/2/2013

3. DESCRIPTION OF CLAIM (IF KNOWN):
Linen that was not returned after service was terminated.

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 17482.29 (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: Randi Gertler
Title: Vice President
Company: Oceanside Inst. Industries
Address and telephone number (if different from notice address above):

Telephone number: 516-766-1461

Randi Gertler (Signature) 1/29/14 (Date)

email: Randi@oceansidelaundry.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.

For the Finest
Ocean Side

Oceanside Institutional Industries Inc.

INVOICE

2525 Long beach Road
Oceanside, New York 11572
Phone: 516-766-1461
Fax: 516-678-0980

DATE: 11/19/2013
INVOICE # SSMC111913
Customer ID 00-soun002

BILL TO

Sound Shore Medical Center
16 Guion Place
New Rochelle, NY 10801
Contact: Barbara Crowley

Item	Pieces Lost	Est. W.T.	Poundage		AMOUNT
00100 - LARGE SHEET	1073	1.1040	1185		$ 6,941.88
00300 - BATH TOWEL	522	0.4340	226		$ 1,327.25
00400 - PILLOW CASE	270	0.1800	49		$ 285.28
00500 - PATIENT GOWN	417	0.6000	250		$ 1,464.94
00600 - DIAPER	0	0.2500	0		$ -
00505 - MAGNA GOWN	18	0.7500	13		$ 78.98
00700 - LINEN SAVER	555	1.2000	666		$ 3,900.24
00810 - KNIT CONTOUR SHEET	124	1.4300	177		$ 1,038.16
00900 - THERMAL BLANKET	142	2.2500	320		$ 1,875.03
02100 - O. R. TOWEL	137	0.1800	25		$ 144.21
04153 - LAUNDRY BAG	0	0.1000	0		$ -
02150 - OR PILLOW CASE	0	0.0000	0		$ -
02205 - OR LARGE SHEET	2	1.2000	2		$ 13.61
02600 - ISOLATION GOWN	2	0.4430	1		$ 6.04
02690 - I.V.GOWN	28	0.4430	13		$ 73.96
02800 - WRAPPER - 24" X 24"	7	0.2500	2		$ 10.71
02900 - WRAPPER - 36" X 36"	7	0.3500	3		$ 15.35
02950 - WRAPPER - 45" X 45"	8	0.4500	4		$ 21.27
03100 - WRAPPER - 54" X 54"	7	0.5500	4		$ 22.67
03400 - BABY DIAPER	5	0.2500	1		$ 7.66
03600 - T-SHIRT	29	0.1000	3		$ 17.02
03700 - PEDIATRIC GOWN	8	0.2700	2		$ 12.04
03800 - RECEIVING BLANKET	120	0.2800	34		$ 197.56
07500 - WASHCLOTH	108	0.0450	5		$ 28.43
Total Poundage			2983		2983
Replacement Cost Per Pound					$ 5.86

Subtotal	$ 17,482.29
	$ -
	$ -
Tax due	$ -
Other	$ -
TOTAL Due	**$ 17,482.29**

OTHER COMMENTS

1. Total payment due In 30 days
2. Please include the invoice number on your check

Make all checks payable to
Oceanside Institutional Industries Inc.

If you have any questions about this invoice, please contact
Jack Ferrara Jr. 516-766-1461 Ext. 233 Admin@OceansideLaundry.com

Thank You For Your Business!

From: (516) 248-6400 Origin ID: TKLA
Richard G. Gertler
Davidoff Hutcher & Citron LLP
200 Garden City Plaza
Suite 315
Garden City, NY 11530

FedEx Express

J14101312270326

Ship Date: 31JAN14
ActWgt: 0.5 LB
CAD: 100607353/INET3490

Delivery Address Bar Code

Ref # 11449 001
Invoice #
PO #
Dept #

SHIP TO: (000) 000-0000 BILL SENDER
c/o GCG
Sound Shore Medical of Westchester
5151 BLAZER PKWY
STE A
DUBLIN, OH 43017

SATURDAY 12:00P
PRIORITY OVERNIGHT

TRK# 0201 7977 8908 7410

43017
OH-US
LCK

X0 OSUA

522G1/06EC/F220

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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.

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	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): OCEANSIDE Institutional Industries, 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.

THE GARDEN CITY GROUP, INC. FEB - 1 2014

Name and Addresses Where Notices Should be Sent:
2525 Long Beach Road
Oceanside, NY 11572

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): 11/2/2013

3. DESCRIPTION OF CLAIM (IF KNOWN): Linen that was not returned after service was terminated.

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 5266.32 (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: Randy Gertler
Title: Vice President
Company: Oceanside Institutional Industries
Address and telephone number (if different from notice address above):

Telephone number: 516-766-1461

(Signature) 1/29/14 (Date)

email: Randi@OceansideLaundry.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.

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For the Finest
Ocean Side

Oceanside Institutional Industries Inc

INVOICE

2525 Long beach Road
Oceanside, New York 11572
Phone: 516-766-1461
Fax: 516-678-0980

DATE:	11/19/2013
INVOICE #	MTVFB111913
Customer ID	00-mtver00

BILL TO

Mount Vernon
16 Guion Place
New Rochelle, NY 10801
Contact: Barbara Crowley

Item	Pieces Lost	Est. W.T.	Poundage	AMOUNT
00100 - LARGE SHEET	482	1.1040	532	$ 3,117.83
00300 - BATH TOWEL	235	0.4340	102	$ 596.78
00400 - PILLOW CASE	129	0.1800	23	$ 135.81
00500 - PATIENT GOWN	248	0.6000	149	$ 872.67
00600 - DIAPER	0	0.2500	0	$ -
00505 - MAGNA GOWN	0	0.7500	0	$ 1.13
00700 - LINEN SAVER	0	1.2000	0	$ -
00810 - KNIT CONTOUR SHEET	59	1.4300	85	$ 497.02
00900 - THERMAL BLANKET	0	2.2500	0	$ -
02100 - O. R. TOWEL	26	0.1800	5	$ 27.57
04153 - LAUNDRY BAG	0	0.1000	0	$ 0.28
02150 - OR PILLOW CASE	0	0.0000	0	$ -
02205 - OR LARGE SHEET	0	1.2000	0	$ -
02600 - ISOLATION GOWN	0	0.4430	0	$ -
02690 - I.V.GOWN	0	0.4430	0	$ -
02800 - WRAPPER - 24" X 24"	0	0.2500	0	$ -
02900 - WRAPPER - 36" X 36"	0	0.3500	0	$ -
02950 - WRAPPER - 45" X 45"	0	0.4500	0	$ -
03100 - WRAPPER - 54" X 54"	0	0.5500	0	$ -
03400 - BABY DIAPER	0	0.2500	0	$ -
03600 - T-SHIRT	0	0.1000	0	$ -
03700 - PEDIATRIC GOWN	0	0.2700	0	$ -
03800 - RECEIVING BLANKET	0	0.2800	0	$ -
07500 - WASHCLOTH	65	0.0450	3	$ 17.23
Total Poundage			899	899
Replacement Cost Per Pound				$ 5.86

Subtotal	$ 5,266.32
	$ -
	$ -
Tax due	$ -
Other	$ -
TOTAL Due	**$ 5,266.32**

OTHER COMMENTS

1. Total payment due in 30 days
2. Please include the invoice number on your check

Make all checks payable to
Oceanside Institutional Industries Inc.

If you have any questions about this invoice, please contact
Jack Ferrara Jr. 516-766-1461 Ext. 233 Admin@OceansideLaundry.com

Thank You For Your Business!

From: (516) 248-6400 Origin ID: TKLA
Richard G Gertler
Davidoff Hutcher & Citron LLP
200 Garden City Plaza
Suite 315
Garden City, NY 11530

J1410131227032G

Ship Date: 31JAN14
ActWgt: 0.5 LB
CAD: 100607353/INET3490

Delivery Address Bar Code

Ref # 11449.001
Invoice #
PO #
Dept #

SHIP TO: (000) 000-0000 BILL SENDER
c/o GCG
Sound Shore Medical of Westchester
5151 BLAZER PKWY
STE A
DUBLIN, OH 43017

SATURDAY 12:00P
PRIORITY OVERNIGHT

TRK# 0201 7977 8908 7410

X0 OSUA

43017
OH-US
LCK

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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.

Filed - 0134

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	**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)
Oceanside Institutional Industries, 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.

THE GARDEN CITY GROUP, INC. FEB - 1 2014

Name and Addresses Where Notices Should be Sent:
2525 Long Beach Road
Oceanside, Ny 11572

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): 11/2/2013

3. DESCRIPTION OF CLAIM (IF KNOWN):
Linen that was not returned after Service was terminated.

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 12 137.04 (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.

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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: Randi Gertler
Title: Vice President
Company: Oceanside Institutional Industries
Address and telephone number (if different from notice address above):

Randy Gertler (Signature) 1/29/14 (Date)

Telephone number: 516-766-1461 email: Randi@OceansideLaundry.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.

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For the Finest Ocean Side

Oceanside Institutional Industries Inc.

INVOICE

2525 Long beach Road
Oceanside, New York 11572
Phone: 516-766-1461
Fax: 516-678-0980

DATE: 11/19/2013
INVOICE # MHS111913
Customer ID 00-scha002

BILL TO

Michael And Helen Schaffer
16 Guion Place
New Rochelle, NY 10801
Contact: Barbara Crowley

Item	Pieces Lost	Est. W.T.	Poundage		AMOUNT
00100 - LARGE SHEET	663	1.1040	732		$ 4,289.18
00300 - BATH TOWEL	468	0.4340	203		$ 1,191.27
00400 - PILLOW CASE	128	0.1800	23		$ 135.19
00500 - PATIENT GOWN	313	0.6000	188		$ 1,101.30
00600 - DIAPER	229	0.2500	57		$ 335.11
00505 - MAGNA GOWN	0	0.7500	0		$ -
00700 - LINEN SAVER	448	1.2000	538		$ 3,150.82
00810 - KNIT CONTOUR SHEET	75	1.4300	107		$ 627.09
00900 - THERMAL BLANKET	97	2.2500	219		$ 1,282.04
02100 - O. R. TOWEL	0	0.1800	0		$ -
04153 - LAUNDRY BAG	0	0.1000	0		$ -
02150 - OR PILLOW CASE	0	0.0000	0		$ -
02205 - OR LARGE SHEET	0	1.2000	0		$ -
02600 - ISOLATION GOWN	0	0.4430	0		$ -
02690 - I.V.GOWN	0	0.4430	0		$ -
02800 - WRAPPER - 24" X 24"	0	0.2500	0		$ -
02900 - WRAPPER - 36" X 36"	0	0.3500	0		$ -
02950 - WRAPPER - 45" X 45"	0	0.4500	0		$ -
03100 - WRAPPER - 54" X 54"	0	0.5500	0		$ -
03400 - BABY DIAPER	0	0.2500	0		$ -
03600 - T-SHIRT	0	0.1000	0		$ -
03700 - PEDIATRIC GOWN	0	0.2700	0		$ -
03800 - RECEIVING BLANKET	0	0.2800	0		$ -
07500 - WASHCLOTH	95	0.0450	4		$ 25.03
Total Poundage			2071		2071
Replacement Cost Per Pound					$ 5.86

Subtotal	$	12,137.04
	$	-
	$	-
Tax due	$	-
Other	$	-
TOTAL Due	$	12,137.04

OTHER COMMENTS

1. Total payment due in 30 days
2. Please include the invoice number on your check

Make all checks payable to
Oceanside Institutional Industries Inc.

If you have any questions about this invoice, please contact
Jack Ferrara Jr. 516-766-1461 Ext. 233 Admin@OceansideLaundry.com

Thank You For Your Business!

From: (516) 248-6400
Richard G. Gertler
Davidoff Hutcher & Citron LLP
200 Garden City Plaza
Suite 315
Garden City, NY 11530

Origin ID: TKLA

FedEx Express

J14101312270326

Ship Date: 31JAN14
ActWgt: 0.5 LB
CAD: 100607353/INET3490

Delivery Address Bar Code

Ref # 11449.001
Invoice #
PO #
Dept #

SHIP TO: (000) 000-0000 BILL SENDER
c/o GCG
Sound Shore Medical of Westchester
5151 BLAZER PKWY
STE A
DUBLIN, OH 43017

SATURDAY 12:00P
PRIORITY OVERNIGHT

TRK# 7977 8908 7410
0201

43017
OH-US
LCK

X0 OSUA

5Z2G1X5EC/F220

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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.

B 10 (Official Form 10) (12/12)

UNITED STATES BANKRUPTCY COURT	PROOF OF CLAIM
Name of Debtor: SoundShore Medical Ctr@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.*

THE GARDEN CITY GROUP INC. FEB - 5 2014

COURT USE ONLY

Name of Creditor (the person or other entity to whom the debtor owes money or property): Olympus America INC

Name and address where notices should be sent:
Olympus America INC
3500 corporate pkwy
Center Valley PA 18034
Telephone number: 484-896-5000 email: Credit_bankruptcy@olympus.com

☑ Check this box if this claim amends a previously filed claim.
Court Claim Number: N/A (*If known*)
Filed on: 1/30/14 post admin

Name and address where payment should be sent (if different from above):

FILED - 01362
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Telephone number: email:

☐ 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: $ 2,000

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

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

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

2. Basis for Claim: Unsecured post admin claim
(See instruction #2)

3. Last four digits of any number by which creditor identifies debtor:	**3a. Debtor may have scheduled account as:** (See instruction #3a)	**3b. Uniform Claim Identifier (optional):** (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 _____ % ☐ 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: $ 2,000

5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507 (a). If any part 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 $11,725*) 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 $2,600* 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)(__).

$_____

**Amounts are subject to adjustment on 4/1/13 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)

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:

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: Samantha Capasso
Title: Credit Risk Admin
Company: Olympus America Inc
Address and telephone number (if different from notice address above):

Samantha Capasso 2/4/14
(Signature) (Date)

Telephone number: 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 instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, exceptions to these general rules may apply.

Items to be completed in Proof of Claim form

Court, Name of Debtor, and Case Number:
Fill in the federal judicial district in which the bankruptcy case was filed (for example, Central District of California), the debtor's full name, and the case number. If the creditor received a notice of the case from the bankruptcy court, all of this information is at the top of the notice.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount owed to the creditor on the date of the bankruptcy filing. Follow the instructions concerning whether to complete items 4 and 5. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to the claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor:
State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:
Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

3b. Uniform Claim Identifier:
If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:
Check whether the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507 (a).
If any portion of the claim falls into any category shown, check the appropriate box(es) and state the amount entitled to priority. (See Definitions.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Credits:
An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

7. Documents:
Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest and documents required by FRBP 3001(c) for claims based on an open-end or revolving consumer credit agreement or secured by a security interest in the debtor's principal residence. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential health care information. Do not send original documents, as attachments may be destroyed after scanning.

8. Date and Signature:
The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

Fw: Olympus Soundshore
Donald Ulrich to Samantha Capasso 01/31/2014 02:13 PM

Sam,

I just wanted to make sure that you included these in your claim yesterday. The customer just emailed them to me.

Thank you,

Donald R. Ulrich
NYC Territory-Medical Collections Admin.
Medical Systems Group
Olympus America Inc.
3500 Corporate Parkway
Center Valley, PA 18034

Phone: 484-896-3245
Fax: 484-896-7828
donald.ulrich@olympus.com
www.olympus.com

----- Forwarded by Donald Ulrich/HQ/Medical/OAI on 01/31/2014 02:12 PM -----

From: Jazlyn Rosado <JAZROSAD@montefiore.org>
To: "Donald.Ulrich@olympus.com" <Donald.Ulrich@olympus.com>
Cc: "mterrano@verizon.net" <mterrano@verizon.net>
Date: 01/31/2014 02:09 PM
Subject: Olympus Soundshore

These belong to the estate.

Thank you!

Jazlyn Rosado
Accounts Payable Department
Business Information Systems (BIS)

Montefiore Medical Center
The University Hospital for Albert Einstein College of Medicine
200 Corporate Blvd S, Ste 175, Yonkers, NY 10701
914-378-6340 Main Line
914-378-6351 Direct Line
914-378-6375 Fax
jazrosad@montefiore.org
www.montefiore.org

Montefiore

From: acctspayable@montefiore.org [mailto:acctspayable@montefiore.org]
Sent: Friday, January 31, 2014 8:49 AM
To: Jazlyn Rosado
Subject: Message from KMBT_423

SKMBT_42314013113490.pdf

INVOICE

NUMBER
15292782 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P.O. BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO: **OLYMPUS AMERICA INC.**
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
NEW ROCHELLE NY 10801

****** To receive your invoices electronically, please contact your Credit Representative.******

Tax ID: Tax Cert: PAGE: 1

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
NR179449	Net 30 Days	11/25/13		B11	13468981 SP	11/25/13

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
LOANER USAGE FEE		LOANER USAGE FEE LOANER USAGE FEE	1,000.00	
	1	Net Price	1,000.00	1,000.00
70338010		Text Line	.00	
		Net Price		
27734		Text Line	.00	
		Net Price		
		11/25/13 Loaner charge invoiced 13468981-SP/ 580161-US 13136965-DS		
		Loaner delivered 10/28/13		
		Loaner outstanding 31 days		

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
		12/25/13	PAY THIS AMOUNT	USD 1,000.00

Trade-In Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a discount program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S..C.Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R.Sec1002.952 (h). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

INVOICE

NUMBER
15385595 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P.O. BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO:
OLYMPUS AMERICA INC.
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
NEW ROCHELLE NY 10801

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Tax ID: Tax Cert: PAGE: 1

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
NR179449	Net 30 Days	12/26/13		B11	13565437 SP	12/26/13

ITEM NUMBER	QTY. SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
LOANER USAGE FEE		LOANER USAGE FEE LOANER USAGE FEE	1,000.00	
	1	Net Price	1,000.00	1,000.00
70338010		Text Line	.00	
		Net Price		
27734		Text Line	.00	
		Net Price		
		12/26/13: Loaner charge invoiced 13565437 SP/ 580161 US		
		13136965-DS		
		Loaner delivered 10/28/13		
		Loaner outstanding 62 days		

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
		01/25/14	PAY THIS AMOUNT	USD 1,000.00

Trade-in Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a discount program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S..C.Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R.Sec1002.952 (h). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

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)
Olympus America 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:
Olympus America INC
3500 corporate parkway
Center Valley PA 18034
Credit-bankruptcy@olympus.com

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):
UN-Secured post admin claim.

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: Samantha Capasso
Title: Credit Risk Admin
Company: Olympus America INC
Address and telephone number (if different from notice address above).

Samantha Capasso (Signature) 1/29/14 (Date)

Telephone number: _____ 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

INVOICE

NUMBER
15169811 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P.O. BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO:
OLYMPUS AMERICA INC.
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
PO#NR179466
NEW ROCHELLE NY 10801

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Tax ID: Tax Cert: PAGE: 1

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
NR179466	Net 30 Days	10/17/13		600	13348809 S0	10/18/13

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
		ORDERED BY: FRANK HALL		
		VIA: PH		
		PHONE #: 914-365-3893		
		FAX #: 914-632-2134		
		EMAIL: FHALL@SSHSW.ORG		
		CSSR: Kathy Johnson @ 1-800-848-9024		
		*		
K10016135		PLEASE USE K10001147 OR K10016135	140.29	
	1	Net Price	140.29	140.29
1ZV464V60323880084	1	Freight & Handling	10.72	10.72
		THANK YOU FOR YOUR ORDER		

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
		11/17/13	PAY THIS AMOUNT	USD 151.01

Trade-in Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade- n credit may reflect a discount, reduction in price or participation in a discount program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S..C Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R.Sec1002.652 (h). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

INVOICE

NUMBER
15201587 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P O BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO:
OLYMPUS AMERICA INC.
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
ATTN: GI SUITE
PO# NR179626
NEW ROCHELLE NY 10801

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Tax ID: Tax Cert: PAGE: 1

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
NR179626	Net 30 Days	10/29/13		600	13383481 S0	10/29/13

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
		ORDERED BY: FRANK HALL		
		VIA: PHONE		
		PHONE #: 914-365-3893		
		FAX #: 914-632-2134		
		EMAIL: NA		
		CSSR:Dora Lewis @ EXT: 151265 / Center Valley		
		*		
MB-142		MB-142 MOUTHPIECE (ONE PIECE)	10.03	
	25	Net Price	10.03	250.75
MAJ-1555		Disposable biopsy valve. (20/box)	50.00	
	10	Net Price	50.00	500.00
		THANK YOU FOR YOUR ORDER		

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
		11/28/13	PAY THIS AMOUNT	USD 750.75

Trade-in Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a discount program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S..C.Sec 1320a-7b(b) (3) and applicable regulations (42 C F R.Sec1C02.952 (h). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

INVOICE

NUMBER
15231128 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P O. BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO:
OLYMPUS AMERICA INC.
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
PO#4501206172
NEW ROCHELLE NY 10801

**** To receive your invoices electronically, please contact your Credit Representative.****

Tax ID: Tax Cert: PAGE: 1

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
4501206172		11/06/13		600	13412122 S0	11/06/13

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
		ORDERED BY: RENEE HOWELL VIA: PH PHONE #: 914-365-4435 FAX #: EMAIL: RHOWELL@MOTEFIORE.ORG CSSR: Kathy Johnson @ 1-800-848-9024		
5556024		LUBRI-FLEX,6.0 X 24 CM WO/GW	74.00	
	6	Net Price	74.00	444.00
5920002BX		IRRI FLOW II BX 5	165.00	
	6	Net Price	165.00	990.00
41BX		EZ GLIDER TC STRAIGHT TIP GUIDEWIRE BX/5	165.00	
	2	Net Price	165.00	330.00

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
			PAY THIS AMOUNT	USD

Trade-In Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a discount program Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec 1128B(b) (3) of the Social Security Act, 42 U.S..C.Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R.Sec1002.952 (h) Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

INVOICE

NUMBER
15231128 RI

MAIL ALL CORRESPONDENCE TO:

OLYMPUS AMERICA INC.
3500 CORPORATE PARKWAY
P.O. BOX 610
CENTER VALLEY, PA 18034-0610
TEL (484) 896-5000

YOUR CREDIT REPRESENTATIVE IS:
Donald R Ulrich
P 484-896-3245 X103245
F 484-896-7828
Donald.Ulrich@Olympus.com

MAIL REMITTANCE TO:
OLYMPUS AMERICA INC.
Box 200194
Pittsburgh, PA 15251-0194

SOLD TO: 1231950
MONTEFOIRE SS OPERATIONS INC
200 CORPORATE BLVD S STE 175
DBA MONTEFIORE NEW ROCHELLE HOSPITAL INC
YONKERS NY 10701

SHIP TO: 99496
MONTEFIORE NEW ROCHELLE HOSPITAL INC
16 GUION PLACE
PO#4501206172
NEW ROCHELLE NY 10801

**** To receive your invoices electronically, please contact your Credit Representative.****

Tax ID: Tax Cert: PAGE: 2

CUSTOMER P.O. NUMBER	TERMS	REQ. DATE	DELIVERY INSTRUCTIONS	BRANCH PLANT	ORDER NO.	INVOICE DATE
4501206172	Net 30 Days	11/06/13		600	13412122 S0	11/06/13

ITEM NUMBER	QTY SHIP	DESCRIPTION	UNIT PRICE	AMOUNT
582225899695	1	Freight & Handling	13.03	13.03
		THANK YOU FOR YOUR ORDER		

Tax Rate	Sales Tax	Net Due Date		INVOICE TOTAL
		12/06/13	PAY THIS AMOUNT	USD 1,777.03

Trade-in Credit will be issued under a separate document after Olympus receives the trade-in equipment. The trade-in credit may reflect a discount, reduction in price or participation in a discount program. Any such discount or reduction in price is fully and accurately reported herein in accordance with Sec. 1128B(b) (3) of the Social Security Act, 42 U.S..C.Sec. 1320a-7b(b) (3) and applicable regulations (42 C.F.R Sec1002.952 (h). Further, you may be obligated to properly disclose the discount or other reduction in price in costs claimed by you to the Medicare or state healthcare program.

The terms and conditions contained on the reverse side hereof represent the total understanding between the parties governing the sale of the goods described herewith except as modified by the terms of any dealer agreement, sales representative agreement, or any similar arrangement in writing between Olympus and the purchaser.

INVC002 2 of 4 07/24/2009

214
600
fedex.com 1.800.GoFedEx 1.800.463.3339
Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
13-12840-fsd Doc 113 (Part 9) Pg 31 of 39

FedEx Express **US Airbill** FedEx Tracking Number **8582 3168 0565**

Form ID No. 0215 SPHG1

Recipient's Copy

RECIPIENT: PEEL HERE

1 From This portion can be removed for Recipient's records.

Date 2/4/14 FedEx Tracking Number 858231680565 8787-0420-6

Sender's Name Samantha Capasso Phone 484 896-5000

Company OLYMPUS AMERICA

Address 3500 CORPORATE PKWY

Dept./Floor/Suite/Room

City CENTER VALLEY State PA ZIP 18034

2 Your Internal Billing Reference

3 To

Recipient's Name Sandpiper Med Ctr Phone

Company C/O GCG

Recipient's Address 5151 Blazer Parkway

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

Dept./Floor/Suite/Room

Address Suite A

To request a package be held at a specific FedEx location, print FedEx address here

City Dublin State OH ZIP 43017

0338897770

8582 3168 0565

4a Express Package Service *Packages up to 150 lbs.*

- [x] FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected
- [ ] FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.
- [ ] FedEx First Overnight — Earliest next business morning delivery to select locations.* Saturday Delivery NOT available.
- [ ] FedEx 2Day — Second business day.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected
- [ ] FedEx Express Saver — Third business day.* Saturday Delivery NOT available

FedEx Envelope rate not available. Minimum charge: One-pound rate. * To most locations.

4b Express Freight Service *Packages over 150 lbs.*

- [ ] FedEx 1Day Freight* — Next business day** Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
- [ ] FedEx 2Day Freight — Second business day** Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected
- [ ] FedEx 3Day Freight — Third business day.** Saturday Delivery NOT available.

* Call for Confirmation: ** To most locations.

5 Packaging

- [x] FedEx Envelope*
- [ ] FedEx Pak* — Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak.
- [ ] FedEx Box
- [ ] FedEx Tube
- [ ] Other

* Declared value limit $500.

6 Special Handling — Include FedEx address in Section 3.

- [ ] SATURDAY Delivery — Not available for FedEx Standard Overnight, FedEx First Overnight, FedEx Express Saver, or FedEx 3Day Freight.
- [ ] HOLD Weekday at FedEx Location — Not available for FedEx First Overnight.
- [ ] HOLD Saturday at FedEx Location — Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

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

- [ ] No
- [ ] Yes — As per attached Shipper's Declaration.
- [ ] Yes — Shipper's Declaration not required.
- [ ] Dry Ice — Dry Ice, 9, UN 1845 ____ x ____ kg
- [ ] Cargo Aircraft Only

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging.

7 Payment Bill to: Enter FedEx Acct. No. or Credit Card No. below. Obtain Recip. Acct. No [ ]

- [x] Sender — Acct. No in Section 1 will be billed
- [ ] Recipient
- [ ] Third Party
- [ ] Credit Card
- [ ] Cash/Check

Total Packages Total Weight Total Charges

Credit Card Auth.

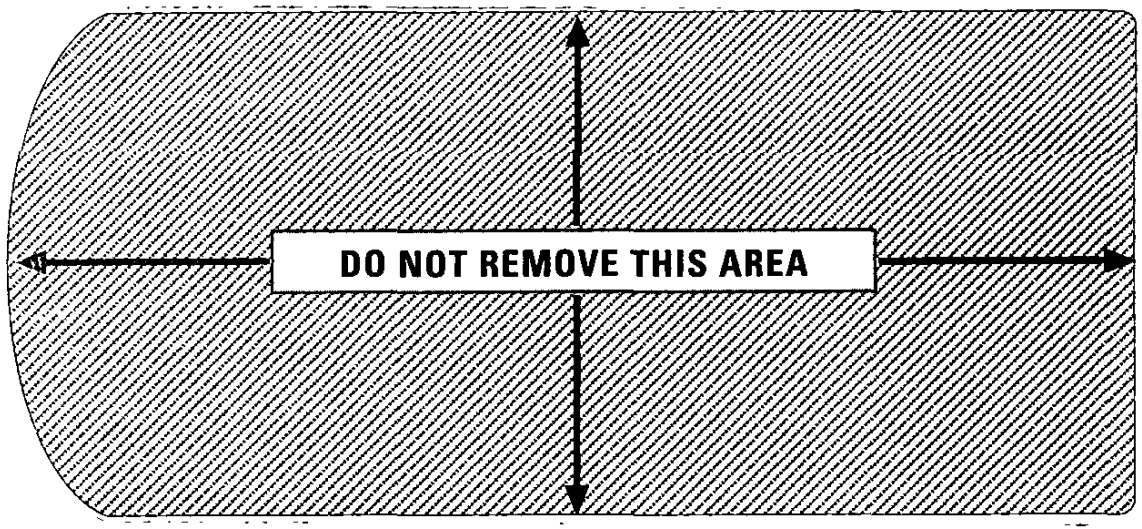
†Our liability is limited to $100 unless you declare a higher value. See the current FedEx Service Guide for details.

8 *NEW* Residential Delivery Signature Options If you require a signature, check Direct or Indirect.

- [ ] No Signature Required — Package may be left without obtaining a signature for delivery
- [ ] Direct Signature — Anyone at recipient's address may sign for delivery. *Fee applies.*
- [ ] Indirect Signature — If no one is available at recipient's address, anyone at a neighboring address may sign for delivery. *Fee applies.*

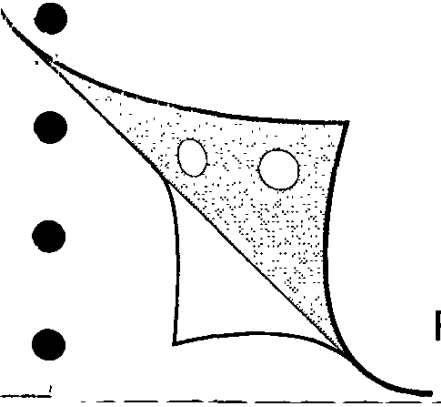
519

Rev. Date 11/05•Part #158279•©1994–2005 FedEx•PRINTED IN U.S.A.•SRS



Peel and Stick FedEx US Airbill

1. Complete front page of the Airbill.
2. Retain "Sender's Copy" for your records.
3. Remove label backing.
4. Adhere Airbill to front of package.
   Please DO NOT remove "FedEx Copy."



PEEL FROM THIS CORNER.

13-12840-mkd Doc 113-1 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 9) Pg 32 of 39

THE GARDEN CITY GROUP, INC. FEB - 3 2014

FILED - 01347

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	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)
Orthosonics Limited

☐ 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
Orthosonics Limited
3451 Plano Parkway
Lewisville, TX 75056
Attn: Brent Alldredge, Esq.

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) December 11, 2012

3. DESCRIPTION OF CLAIM (IF KNOWN) Medical Devices (see attached)

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM. $ 2,700.00 (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: Emily Buxton
Title: Director
Company: Orthosonics Limited
Address and telephone number (if different from notice address above)

(Signature) (Date) 1/6/2014

Telephone number: 214-937-2000 email: emilybuxton@orthofix.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.

ORTHOSONICS
An Orthofix Company
71 Passaic Avenue, Chatham, NJ 07928
Tel: 973 665 0001 Fax: 973 665 0039
accountsus@orthosonics.com www.orthosonics.com

SALES INVOICE

Invoice No.	OP/I611805
Date	12/13/2012
Account No.	I$8568
Your Order Ref	NR174042
Our Order No.	410920

INVOICE TO:

SOUND SHORE MEDICAL CENTER OF
WESTCHESTER - ACCS PAYABLE DEPT
16 GUION PLACE
NEW ROCHELLE
NY 10802

DELIVER TO:

SOUND SHORE MEDICAL CENTER OF
WESTCHESTER - OPERATING ROOM
16 GUION PLACE
NEW ROCHELLE
NY 10802

Date Order Received 12/11/2012

Date Order Despatched 12/12/2012

	PRODUCT	DESCRIPTION	QTY	LIST PRICE	DISCOUNT	NETT PRICE	NETT VALUE	V/C
NJ	OHFO2060SU	6mm Flat Osteotome probe	1	400.00		400.00	400.00	999
NJ	OHSO2060SU	6mm Serrated Osteotome probe	1	400.00		400.00	400.00	999
NJ	OHP2080SU	8mm Single use Piercer probe	1	400.00		400.00	400.00	999
	USOC	OSCAR HIRE WITH COMBINATION SU PROBES	1	1,500.00		1,500.00	1,500.00	999
		PT: MERCURIO 12/4/12						

VAT DETAILS	RATE	AMOUNT	VAT AMOUNT
999	0.00	2,700.00	0.00

TOTAL NET	2,700.00
TOTAL SALES TAX	0.00
TOTAL VALUE	2,700.00

Please make cheques payable to : ORTHOSONICS LTD, 71 Passaic Avenue, Chatham, NJ 07928
Bank of America Account No. : 695679176 IBAN: GB75 BOFA 1650 5049 1710 28 ABA : 053000196

Terms Strictly 30 days **Full terms and conditions available on request** **All amounts are in US$**

If you have any queries on this invoice please contact Bev Katana on 973 665 0001.
**** To receive your invoice electronically, forward your email address to accountsus@orthosonics.com ****
Please issue a remittance advice quoting our invoice number.

Vat Reg. No: GB 585 4623 12
Orthosonics Limited is registered in Scotland No. SC127003
Registered Address: 24 Great King Street, Edinburgh, EH3 6QN

ORIGIN ID:ADSA (214) 937-2168
ANGELA LUTES
ORTHOFIX
3451 PLANO PKWY

LEWISVILLE, TX 75056
UNITED STATES US

SHIP DATE: 31JAN14
ACTWGT: 0.1 LB
CAD: 650571/CAFE2704

BILL SENDER

TO **C/O GCG**
SOUND SHORE MEDICAL OF WESTCHASTER
5151 BLAZER PKWY
SUITE A
DUBLIN OH 43017
(214) 937-2168
DEPT: LEGAL

REF: 525-ORTHOSONIC

FedEx Express

REL# 3785346

MON - 03 FEB 8:00A
FIRST OVERNIGHT

TRK# 0201 **4412 8453 5020**

X1 OSUA

43017
OH-US **LCK**

56140-434 RIT2 10/13

FILED 0466
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

Amendment to

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)
Pomco, 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

THE GARDEN CITY GROUP, INC. FEB 22 2014

Name and Addresses Where Notices Should be Sent:
Pomco, Inc.
2425 James Street
Syracuse, NY 13206

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): Payment of debtors health plan claims to Sound Shore employees/Mt. Vernon employees by third party administrator and fees.

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $25,989.13. (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: Kathleen Lamb
Title: General Counsel
Company: Pomco, Inc.
Address and telephone number (if different from notice address above):
2425 James Street
Syracuse, NY 13206
Telephone number: (315) 432-9711 x 4462

Kathleen Lamb (Signature) 2/12/14 (Date)

email: klamb@pomcogroup.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

Sound Shore Medical Center
Outstanding Invoices

Date of Invoice	Type	Amount	Notes
12/31/13	Medical	$ 8,469.21	Contains POMCO Service Fees of $5,709.73
01/03/14	Dental	$ 72.00	
01/08/14	Medical	$ 3,524.31	
01/15/14	Medical	$3,688.49	Contains POMCO Service Fees of $2,284.46
01/22/14	Medical	$ 11,187.66	Contains POMCO Service Fees of $2689.46
01/22/14	Dental	$ 1,883.07	
01/29/14	Medical	$ 2,507.17	Contains POMCO Service Fees of $2284.46
01/29/14	Dental	$ 6,051.72	
02/10/14	Medical	$ 10,181.10	Contains POMCO Service Fees of $3060.71
02/10/14	Dental	$ 827.00	
		$ 48,391.73	

Mount Vernon Hospital
Outstanding Invoices

Date of Invoice	Type	Amount	Notes
12/31/13	Medical	$ 1,665.54	The entire amount is POMCO Service Fees
01/08/14	Medical	$ 65.63	
01/15/14	Medical	$ 597.22	The entire amount is POMCO Service Fees
01/22/14	Medical	$ 1,743.57	Contains Service Fees of $578.47
01/29/14	Medical	$ 1,477.22	

02/06/14	Medical	$ 1,451.02	Contains POMCO Service Fees of $477.22
02/13/14	Medical	$ 597.20	Contains POMCO Service Fees
		$ 7,597.40	

Total: $55,989.13

13-22840-rdd Doc 1139-11 Entered 06/29/15 15:01:16 Claims of 39

2425 James Street • Syracuse, New York 13206-2899

Presort
First Class Mail
PomBasPrice

U.S. POSTAGE PITNEY BOWES
ZIP 13206
02 1W
0001377277 FEB 14 2014
$ 000.43⁵

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

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.
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☐ 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)
LORNA A REID

☐ 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 13 2014

Name and Addresses Where Notices Should be Sent:
LORNA A REID
15 SCHUDY PL
NEW ROCHELLE
N.Y. 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: Sound Shore Medical Center of Westchester

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) PENSION FUND

2. DATE DEBT WAS INCURRED (IF KNOWN): 2005 to NOV. 5, 2013

3. DESCRIPTION OF CLAIM (IF KNOWN).

4. *TOTAL AMOUNT OF ADMINISTRATIVE CLAIM:* $ 93,174.35 (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: LORNA A REID
Title: RN
Company: _____
Address and telephone number (if different from notice address above):

Telephone number: 914-633-5826

L m A Reid (Signature) 1-31-14 (Date)

email lorn1121@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 - 01460
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK | **PROOF OF CLAIM**

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

Your Claim is Scheduled As Follows:

NOTE: *Other than claims asserting administrative priority under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for administrative expenses arising after the commencement of the case. You may file a request for payment of an administrative expense pursuant to 11 U.S.C. § 503(b).*

Name of Creditor (the person or other entity to whom the Debtor owes money or property): LORNA REID

❑ Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number: _____ *(If known)*

Filed on: _____

Name and address where notices should be sent:

LORNA REID
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

Telephone number: H 914-633-5826 C 914-262-8726
Email Address: lorn1121@gmail.com

Name and address where payment should be sent (if different from above):

Telephone number: 914-633-5826
Email Address: lorn1121@gmail.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.

If an amount is identified above, you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor, you do not need to file this proof of claim form, EXCEPT AS FOLLOWS: If the amount shown is listed as any of DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

1. Amount of Claim as of Date Case Filed (May 29, 2013): $ 93,174.35

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

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

If all or part of the claim arises from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business, pursuant to 11 U.S.C. § 503(b)(9), complete item 6.

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

2. Basis for Claim: _____
(See instruction #2)

3. Last four digits of any number by which creditor identifies Debtor: 0 8 8 4

3a. Debtor may have scheduled account as: _____ (See instruction #3a)

3b. Uniform Claim Identifier (optional): _____ (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 _____ % ❑ 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 part 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).

❑ 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).

❑ 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).

❑ Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).

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

❑ Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(__).

Amount entitled to priority: $93,174.35

**Amounts are subject to adjustment on 4/1/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Claim Pursuant to 11 U.S.C. § 503(b)(9): Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim. $ _____

7. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #7)

8. **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, and security agreements. 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. (*See instruction #8, 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: _____

9. **Signature:** (See instruction #9) 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: LORNA A REID (Signature) 9-12-2013 (Date)

Title: RN, MS

Company: Sound Shore Medical Center of Westchester

Address and telephone number (if different from notice address above):

_____

_____

_____

Telephone number: _____ 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 instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the Debtor, exceptions to these general rules may apply. 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. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

THE GENERAL BAR DATE IN THESE CHAPTER 11 CASES IS SEPTEMBER 16, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)
THE GOVERNMENTAL BAR DATE IN THESE CHAPTER 11 CASES IS NOVEMBER 25, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)

Items to be completed in Proof of Claim Form

Court, Name of Debtor, and Case Number:
These chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on May 29, 2013 (the "Commencement Date"). You should select the Debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount owed to the creditor on the Petition Date. Follow the instructions concerning whether to complete items 4, 5 and 6. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor: State only the last four digits of the Debtor's account or other number used by the creditor to identify the Debtor.

3a. Debtor May Have Scheduled Account As:
Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the Debtor.

3b. Uniform Claim Identifier:
If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:
Check whether the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a):
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Claim Pursuant to 11 U.S.C. § 503 (b)(9):
If you have a claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of the Debtor's business, state the amount of such claim and attach documentation supporting such claim. (See DEFINITIONS, below)

7. Credits:
An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

8. Documents:
Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential healthcare information. Do not send original documents, as attachments may be destroyed after scanning.

9. Date and Signature:
The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, attach a complete copy of any power of attorney, and provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor
A Debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor
A creditor is the person, corporation, or other entity to whom the Debtor owes a debt that was incurred before the date of the bankruptcy filing. See 11 U.S.C. § 101(10).

Claim
A claim is the creditor's right to receive payment for a debt owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim
A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the Debtor on the date of the bankruptcy filing. The creditor must file the form with GCG as described in the instructions above and in the Bar Date Notice.

Section 503(b)(9) Claim
A Section 503(b)(9) claim is a claim for the value of any goods received by the Debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business.

Secured Claim Under 11 U.S.C. § 506(a)
A secured claim is one backed by a lien on property of the Debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a Debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the Debtor money (has a right to setoff).

Unsecured Claim
An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor must show only the last four digits of any social-security, individual's tax-identification, or financial-account number, only the initials of a minor's name, and only the year of any person's date of birth. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information.

INFORMATION

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim
To receive a date-stamped copy of your proof of claim form, please provide a self-addressed stamped envelope and a copy of your proof of claim form when you submit the original to GCG. You will also receive an acknowledgment letter from GCG after your proof of claim form has been processed.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the Debtor. These entities do not represent the bankruptcy court or the Debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Display of Proof of Claim on Case Administration Website
As the official claims agent, and in accordance with Federal Bankruptcy Rule 9037(g), GCG will display the first page of your proof of claim form on the case administration website. Please be aware that any personal information not otherwise redacted on your proof of claim form will be displayed over the Internet.

01001633
SSM0203341877

LORNA REID
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 6 of 40

Name Lorna A Reid 1001633 SSM0203341877
SS# 089-66-0884
Employed By *Sound Shore Medical Center of Westchester*

Your Honor,

Also atatched is a copy of my 2013 accured Sick Time in hours equal to334.37 at hourly rate of $46.5120 amounting to $15,552.21

Copy of the 3% Temporary Salary Reduction Note which was scheduled for period July 2007 to January 2008. This Temporary Salary Reduction is still in effect to present date. Up until June 2013 I was not given a date when this 3% Temporery Salary Reduction will be refunded.

Respectfully Yours,

Lorna A. Reid RN. MS.
Performance Improvement Coordinator/Stroke Coordinator,
Sound Shore Medical Center of Westchester
16 Guion Place, New Rochelle, NY 10801
914-262-8726 ©
lorn1121@gmail.com

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 7 of 40

Name Lorna A Reid 1001633 SSM0203341877
SS# 089-66-0884
Employed By Sound Shore Medical Center of Westchester Chapter 11 Case. No. 13-22840 (RDD)
Date of Hire 06/04/1984 to present date.
Address 15 Schudy Place, New Rochelle, NY 10801
Phone 914-633-5826 (H) 914-262-8726 ©
e-mail lorn1121@gmail.com

Sound Shore Medical Center of Westchester, et al
c/c GCG, Inc.
PO Bx. 9982
Dublin, OH 43017-5982

United States Bankruptcy Court For The Southern District Of New York

Your Honor,

Below represents my estimated Pension Fund that Sound Shore Medical Center of Westchester has not made any contributios towards from 2005 to present date

Year	Salary	Percentage Rate	Estimated Contribution
2005	$97,326.97	8.92%	$8,681.56
2006	$100,042.09	8.92%	$8,923.75
2007	$87,923.86	8.92%	$7,842.80
2008	$92,396.86	10.70%	$9,866.40
2009	$85,712.90	10.70%	$9,171.28
2010	$82,312.08	10.70%	$8,807.39
2011	$86,271.70	10.70%	$9,231.07
2012	$88,588.89	10.70%	$9,479.01
Jun-13	$52,326.00	10.70%	$5,598.88
			Total = $77,622.14

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 8 of 40

Name Lorna A Reid 01001633 SSM0203341877
SS# 089-66-0884
Employed By Sound Shore Medical Center of Westchester
Date of Hire 06/04/1984 to present date.
Address 15 Schudy Place, New Rochelle, NY 10801
Phone 914-633-5826 (H) 914-262-8726 ©
e-mail lorn1121@gmail.com

Chapter 11 Case. No. 13-22840 (RDD)

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Jun-13	$52,326.00	10.70%	$5,598.88
		Total =	$77,622.14

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

GCG #	Claim #	Filed Date	Creditor Name	Debtor Name	Total Scheduled Amount	Total Claimed Amount	Total Allowed Amount
1001633	748	09/16/13	LORNA REID	Sound Shore Medical Center of Westchester	$93,174.35 (Unliquidated)		
				Search Results Total	**$0.00**	**$93,174.35**	**$0.00**

The majority of claims, either filed or as set forth on the Debtors' Schedules of Assets and Liabilities, can be located through the Creditor Search. In addition, a Claims Register can be obtained by clicking the "Save as Excel" button. However, pursuant to an Order of the Bankruptcy Court dated March 12, 2013 [Docket No. 78], claim information for customers must be redacted to preserve confidentiality. Images for those claims will not be made available. If you have any questions regarding this case, please contact ssmTeam@gcginc.com

- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

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- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Health System

Sound Shore Medical Center • The Mount Vernon Hospital • Schaffer Extended Care Center • Hopfer School of Nursing

DATE: July 16, 2007

TO: DIRECTORS OF SERVICE
MEMBERS of MANAGEMENT COUNCIL

FROM: John R. Spicer

For the past few months, our healthcare system has been dealing with a difficult cash position. This has developed in large part from a lower than budgeted volume of services, and a less than budgeted case mix.

Our response has been to significantly reduce overtime and implement a limited restructuring plan. Now, a temporary salary reduction plan will occur from the first pay period in July to January 1, 2008. Those affected will be designated supervisory and managerial employees and salaried positions. This temporary salary reduction of 3% will allow the system to keep on track to achieve its patient care goals and minimize position reductions. We anticipate a cash turnaround by year end with the State's release of funds that are owed to both Sound Shore and Mount Vernon Hospitals.

I know you all understand our current situation, and I also know that we will continue to work collaboratively. In consideration of your support and dedication to SSHS, those experiencing this temporary salary reduction will be offered an additional five vacation days to be used before March 31, 2008.

Human Resources will follow up with more detail.

Thank you for your cooperation.

16 Guion Place • New Rochelle, NY 10802 • Tel: 914-632-5000 x 3700 • Fax: 914-637-1516
Member Pinnacle Healthcare

Claims
Entered 06/29/15 15:01:16
Filed 06/29/15 Pg 12 of 40
(Part 10)
Doc 1139-12
13-22840-rdd

SOUND SHORE HEALTH SYSTEM
PAID TIME OFF REPORT YEAR 2013

Employee Name: Lorna Reid Position: _____ Date of Hire _____

	VACATION DAY			HOLIDAY			FREE DAYS			SICK DAYS			
	Carried over from 2012 __			Carried over from 2012			Carried over from 2012			Carried over from 2012			
	ACCRUED	TAKEN	AVAILABLE	ACCRUED	TAKEN	AVAILABLE	ACCRUED	TAKEN	AVAILABLE	PB	ACCRUED	TAKEN	AVAILABLE
January	150	—	150	60	15	45	30	7.5	22.5	289.37	7.5	—	296.87
February	150	—	150	45	7.5	37.5	22.5	—	22.5	296.87	7.5	—	304.37
March	150	—	150	37.5	—	37.5	22.5	—	22.5	304.37	7.5	7.5	304.37
April	150	7.5	142.5	37.5	—	37.5	22.5	—	22.5	304.37	7.5	—	311.87
May	142.5	—	142.5	37.5	7.5	30	22.5	—	22.5	311.87	7.5	7.5	311.87
June	142.5	—	142.5	30	—	30	22.5	—	22.5	311.87	7.5	—	319.37
July	142.5	15	127.5	30	7.5	22.5	22.5	15	7.5	319.37	7.5	—	326.87
August	127.5	45	82.5	22.5	—	22.5	7.5	—	7.5	326.87	7.5	—	334.37
September										334.37			
October													
November													
December													

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	H				D	D						D	D						D	D	H					D	D			H-D	
February		D	D						D	D						D	D	43					D	D						
March		D	D						D	D					S	D	D						D	D					D	D
April						D	D		D				D	D						D	D				V			P	D		
May			S	D	D						D	D						D	D						D	D	H				
June	D	D						D	D		D																				
July						D	D			H			D	D					FD	D	D				V	V	D	D	F		
August			D	D			V	V	V	D	D	F	V	V		V	D	D						D	D					D	
September	D						V	V																							
October																															
November																															
December																															

** BANK TIME***
VACATION: ____
HOLIDAY: ____
SICK: ____
FREE: ____

Attn: Claims Processing
Kelley Drye & Warren LLP
101 Park Avenue
New York, NY 10178
Sears Holdings Corporation
c/o Epiq Bankruptcy Solutions, LLC
P.O. Box 5097
Portland, OR 97208-5097
U.S. POSTAGE
NEW ROCHELLE, NY
FEB 27 14
PRIORITY
$1.40
00025765-06
43017

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)
LORNA A REID

☐ 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 13 2014

Name and Addresses Where Notices Should be Sent:
LORNA A REID
15 SCHUDY PL
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: Sound Shore Medical Center of Westchester

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): Pension Fund

2. DATE DEBT WAS INCURRED (IF KNOWN): 2005 to Nov. 5th 2013

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 93,174.35 (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: LORNA A REID
Title: RN
Company: _____
Address and telephone number (if different from notice address above):

(Signature) (Date) 1-31-14

Telephone number: 914-633-5826 email: lorn1121@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 - 01461
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

PROOF OF CLAIM

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

NOTE: *Other than claims asserting administrative priority under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for administrative expenses arising after the commencement of the case. You may file a request for payment of an administrative expense pursuant to 11 U.S.C. § 503(b).*

Name of Creditor (the person or other entity to whom the Debtor owes money or property): LORNA REID

☐ Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number: _____ *(If known)*

Filed on: _____

Name and address where notices should be sent:

LORNA REID.
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

Telephone number: H 914-633-5826 C 914-262-8726
Email Address: lorn1121@gmail.com

Name and address where payment should be sent (if different from above):

Telephone number: 914-633-5826
Email Address: lorn1121@gmail.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.

Your Claim is Scheduled As Follows:

If an amount is identified above, you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor, you do not need to file this proof of claim form. EXCEPT AS FOLLOWS: If the amount shown is listed as any of DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

1. Amount of Claim as of Date Case Filed (May 29, 2013): $ 93,174.35

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

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

If all or part of the claim arises from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business, pursuant to 11 U.S.C. § 503(b)(9), complete item 6.

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

2. Basis for Claim: _____
(See instruction #2)

3. Last four digits of any number by which creditor identifies Debtor: 0 8 8 4

3a. Debtor may have scheduled account as: _____ (See instruction #3a)

3b. Uniform Claim Identifier (optional): _____ (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 _____ **%** ☐ 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 part 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).

☐ 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).

☐ 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).

☐ Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).

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

☐ Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(__).

Amount entitled to priority:
$ 93,174.35

**Amounts are subject to adjustment on 4/1/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Claim Pursuant to 11 U.S.C. § 503(b)(9): Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim. $ _____

7. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #7)

8. **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, and security agreements. 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. (*See instruction #8, 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: _____

9. **Signature:** (See instruction #9) 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: LORNA A REID (Signature) 9-12-2013 (Date)

Title: RN, MS

Company: Sound Shore Medical Center of Westchester

Address and telephone number (if different from notice address above):

_____

_____

_____

Telephone number: _____ 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 instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the Debtor, exceptions to these general rules may apply. 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. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

THE GENERAL BAR DATE IN THESE CHAPTER 11 CASES IS SEPTEMBER 16, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)
THE GOVERNMENTAL BAR DATE IN THESE CHAPTER 11 CASES IS NOVEMBER 25, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)

Items to be completed in Proof of Claim Form

Court, Name of Debtor, and Case Number:
These chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on May 29, 2013 (the "Commencement Date"). You should select the Debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount owed to the creditor on the Petition Date. Follow the instructions concerning whether to complete items 4, 5 and 6. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor: State only the last four digits of the Debtor's account or other number used by the creditor to identify the Debtor.

3a. Debtor May Have Scheduled Account As:
Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the Debtor.

3b. Uniform Claim Identifier:
If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:
Check whether the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a):
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Claim Pursuant to 11 U.S.C. § 503(b)(9):
If you have a claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of the Debtor's business, state the amount of such claim and attach documentation supporting such claim. (See DEFINITIONS, below)

7. Credits:
An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

8. Documents:
Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential healthcare information. Do not send original documents, as attachments may be destroyed after scanning.

9. Date and Signature:
The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, attach a complete copy of any power of attorney, and provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor
A Debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor
A creditor is the person, corporation, or other entity to whom the Debtor owes a debt that was incurred before the date of the bankruptcy filing. See 11 U.S.C. § 101(10).

Claim
A claim is the creditor's right to receive payment for a debt owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim
A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the Debtor on the date of the bankruptcy filing. The creditor must file the form with GCG as described in the instructions above and in the Bar Date Notice.

Section 503(b)(9) Claim
A Section 503(b)(9) claim is a claim for the value of any goods received by the Debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business.

Secured Claim Under 11 U.S.C. § 506(a)
A secured claim is one backed by a lien on property of the Debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a Debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the Debtor money (has a right to setoff).

Unsecured Claim
An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor must show only the last four digits of any social-security, individual's tax-identification, or financial-account number, only the initials of a minor's name, and only the year of any person's date of birth. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information.

INFORMATION

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim
To receive a date-stamped copy of your proof of claim form, please provide a self-addressed stamped envelope and a copy of your proof of claim form when you submit the original to GCG. You will also receive an acknowledgment letter from GCG after your proof of claim form has been processed.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the Debtor. These entities do not represent the bankruptcy court or the Debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Display of Proof of Claim on Case Administration Website
As the official claims agent, and in accordance with Federal Bankruptcy Rule 9037(g), GCG will display the first page of your proof of claim form on the case administration website. Please be aware that any personal information not otherwise redacted on your proof of claim form will be displayed over the Internet.

01001633
SSM0203341877

LORNA REID
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 19 of 40

Name Lorna A Reid 1001633 SSM0203341877
SS# 089-66-0884
Employed By Sound Shore Medical Center of Westchester

Your Honor,

Also atatched is a copy of my 2013 accured Sick Time in hours equal to334.37 at hourly rate of $46.5120 amounting to $15,552.21

Copy of the 3% Temporary Salary Reduction Note which was scheduled for period July 2007 to January 2008. This Temporary Salary Reduction is still in effect to present date. Up until June 2013 I was not given a date when this 3% Temporery Salary Reduction will be refunded.

Respectfully Yours,

Lorna A. Reid RN. MS.
Performance Improvement Coordinator/Stroke Coordinator,
Sound Shore Medical Center of Westchester
16 Guion Place, New Rochelle, NY 10801
914-262-8726 ©
lorn1121@gmail.com

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 20 of 40

Name	Lorna A Reid	1001633 SSM0203341877	
SS#	089-66-0884		
Employed By	Sound Shore Medical Center of Westchester	Chapter 11 Case. No. 13-22840 (RDD)	
Date of Hire	06/04/1984 to present date.		
Address	15 Schudy Place, New Rochelle, NY 10801		
Phone	914-633-5826 (H) 914-262-8726 ©		
e-mail	lorn1121@gmail.com		

Sound Shore Medical Center of Westchester, et al
c/c GCG, Inc.
PO Bx. 9982
Dublin, OH 43017-5982

United States Bankruptcy Court For The Southern District Of New York

Your Honor,

Below represents my estimated Pension Fund that Sound Shore Medical Center of Westchester has not made any contributios towards from 2005 to present date

Year	Salary	Percentage Rate	Estimated Contribution
2005	$97,326.97	8.92%	$8,681.56
2006	$100,042.09	8.92%	$8,923.75
2007	$87,923.86	8.92%	$7,842.80
2008	$92,396.86	10.70%	$9,866.40
2009	$85,712.90	10.70%	$9,171.28
2010	$82,312.08	10.70%	$8,807.39
2011	$86,271.70	10.70%	$9,231.07
2012	$88,588.89	10.70%	$9,479.01
Jun-13	$52,326.00	10.70%	$5,598.88
			Total = $77,622.14

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 21 of 40

Name Lorna A Reid 01001633 SSM0203341877
SS# 089-66-0884
Employed By Sound Shore Medical Center of Westchester Chapter 11 Case. No. 13-22840 (RDD)
Date of Hire 06/04/1984 to present date.
Address 15 Schudy Place, New Rochelle, NY 10801
Phone 914-633-5826 (H) 914-262-8726 ©
e-mail lorn1121@gmail.com

Sound Shore Medical Center of Westchester, et al
c/c GCG, Inc.
PO Bx. 9982
Dublin, OH 43017-5982

United States Bankruptcy Court For The Southern District Of New York

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Jun-13	$52,326.00	10.70%	$5,598.88
		Total =	$77,622.14

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

GCG #	Claim #	Filed Date	Creditor Name	Debtor Name	Total Scheduled Amount	Total Claimed Amount	Total Allowed Amount
1001633	748	09/16/13	LORNA REID	Sound Shore Medical Center of Westchester	$93,174.35 (Unliquidated)		
				Search Results Total	**$0.00**	**$93,174.35**	**$0.00**

The majority of claims, either filed or as set forth on the Debtors' Schedules of Assets and Liabilities, can be located through the Creditor Search. In addition, a Claims Register can be obtained by clicking the "Save as Excel" button. However, pursuant to an Order of the Bankruptcy Court dated March 12, 2013 [Docket No. 78], claim information for customers must be redacted to preserve confidentiality. Images for those claims will not be made available. If you have any questions regarding this case, please contact ssmTeam@gcginc.com

- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

GCG #	Claim #	Filed Date	Creditor Name	Debtor Name	Total Scheduled Amount	Total Claimed Amount	Total Allowed Amount
1001633	748	09/16/13	LORNA REID	Sound Shore Medical Center of Westchester	$93,174.35 (Unliquidated)		
				Search Results Total	**$0.00**	**$93,174.35**	**$0.00**

The majority of claims, either filed or as set forth on the Debtors' Schedules of Assets and Liabilities, can be located through the Creditor Search. In addition, a Claims Register can be obtained by clicking the "Save as Excel" button. However, pursuant to an Order of the Bankruptcy Court dated March 12, 2013 [Docket No. 78], claim information for customers must be redacted to preserve confidentiality. Images for those claims will not be made available. If you have any questions regarding this case, please contact ssmTeam@gcginc.com

- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Health System

Sound Shore Medical Center • The Mount Vernon Hospital • Schaffer Extended Care Center • Hopfer School of Nursing

DATE: July 16, 2007

TO: DIRECTORS OF SERVICE
MEMBERS of MANAGEMENT COUNCIL

FROM: John R. Spicer

For the past few months, our healthcare system has been dealing with a difficult cash position. This has developed in large part from a lower than budgeted volume of services, and a less than budgeted case mix.

Our response has been to significantly reduce overtime and implement a limited restructuring plan. Now, a temporary salary reduction plan will occur from the first pay period in July to January 1, 2008. Those affected will be designated supervisory and managerial employees and salaried positions. This temporary salary reduction of 3% will allow the system to keep on track to achieve its patient care goals and minimize position reductions. We anticipate a cash turnaround by year end with the State's release of funds that are owed to both Sound Shore and Mount Vernon Hospitals.

I know you all understand our current situation, and I also know that we will continue to work collaboratively. In consideration of your support and dedication to SSHS, those experiencing this temporary salary reduction will be offered an additional five vacation days to be used before March 31, 2008.

Human Resources will follow up with more detail.

Thank you for your cooperation.

16 Guion Place • New Rochelle, NY 10802 • Tel: 914-632-5000 x 3700 • Fax: 914-637-1516
Member Pinnacle Healthcare

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 25 of 40

SOUND SHORE HEALTH SYSTEM
PAID TIME OFF REPORT YEAR 2013

Employee Name: Lorna Reid Position: _____ Date of Hire _____

	VACATION DAY			HOLIDAY			FREE DAYS			SICK DAYS			
	Carried over from 2012 __			Carried over from 2012			Carried over from 2012			Carried over from 2012			
	ACCRUED	TAKEN	AVAILABLE	ACCRUED	TAKEN	AVAILABLE	ACCRUED	TAKEN	AVAILABLE	PB	ACCRUED	TAKEN	AVAILABLE
January	150	—	150	60	15	45	30	7.5	22.5	289.37	7.5	—	296.87
February	150	—	150	45	7.5	37.5	22.5	—	22.5	296.87	7.5	—	304.37
March	150	—	150	37.5	—	37.5	22.5	—	22.5	304.87	7.5	7.5	304.37
April	150	7.5	142.5	37.5	—	37.5	22.5	—	22.5	304.37	7.5	—	311.87
May	142.5	—	142.5	37.5	7.5	30	22.5	—	22.5	311.87	7.5	7.5	311.87
June	142.5	—	142.5	30	—	30	22.5	—	22.5	311.87	7.5	—	319.37
July	142.5	15	127.5	30	7.5	22.5	22.5	15	7.5	319.37	7.5	—	326.87
August	127.5	45	82.5	22.5	—	22.5	7.5	—	7.5	326.87	7.5	—	334.37
September										334.37			
October													
November													
December													

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January	H				D	D						D	D						D	D	1/2					D	D			F-D	
February		D	D						D	D						D	D	43					D	D						
March		D	D						D	B					5	D	B						D	D					D	D
April						D	D						D	D						D	D			V			P	D			
May			S	D	D						D	D						D	D						D	D	H				
June	D	D						D	D										D												
July				HD		D	D/			H5			D	D		V9			FD	D	D				V	V	D	D	F		
August			D	5			V4	V5	V6	1)	1)	F	V8				D	D						D	D					D
September	D						V	V																							
October																															
November																															
December																															

** BANK TIME***
VACATION: ____
HOLIDAY: ____
SICK: ____
FREE: ____

Kirkpatrick Lockhart Preston Gates Ellis LLP
Attn: Scott Greissman, Esq.
599 Lexington Ave.
New York, NY 10022-6030

Delphi Medical Systems, LLC
Attn: Jeffrey Schreiber, Esq.
One Commerce Center
1201 Orange St., Ste. 1100
Wilmington, DE 19801

Blind Shore Nuclear Center
c/o GGC Inc.
P.O. Box 5982
Duluth, GA 30096-5982

U.S. POSTAGE
NEW ROCHELLE, NY
FEB 10 '09
AMOUNT
$1.40
00025765-06

43017

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/aHelen 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)
LORNA A REID

☐ 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 13 2014

Name and Addresses Where Notices Should be Sent. LORNA A REID
15 SCHUDY PL.
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: Sound Shore Medical Center of Westchester

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 PENSION FUND

2. DATE DEBT WAS INCURRED (IF KNOWN): 2005 to Nov. 6, 2013

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM $ 93,174.35 (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: LORNA A REID
Title: RN
Company. _____
Address and telephone number (if different from notice address above)

(Signature) 1-31-14 (Date)

Telephone number 914-633-5826 email: lorn112@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 - 01462
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

UNITED STATES BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

PROOF OF CLAIM

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

NOTE: *Other than claims asserting administrative priority under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for administrative expenses arising after the commencement of the case. You may file a request for payment of an administrative expense pursuant to 11 U.S.C. § 503(b).*

Your Claim is Scheduled As Follows:

If an amount is identified above, you have a claim scheduled by one of the Debtors as shown. (This scheduled amount of your claim may be an amendment to a previously scheduled amount.) If you agree with the amount and priority of your claim as scheduled by the Debtor and you have no other claim against the Debtor, you do not need to file this proof of claim form, EXCEPT AS FOLLOWS: If the amount shown is listed as any of DISPUTED, UNLIQUIDATED, or CONTINGENT, a proof of claim MUST be filed in order to receive any distribution in respect of your claim. If you have already filed a proof of claim in accordance with the attached instructions, you need not file again.

Name of Creditor (the person or other entity to whom the Debtor owes money or property): LORNA REID

☐ Check this box to indicate that this claim amends a previously filed claim.

Court Claim Number: _____ *(If known)*

Filed on: _____

Name and address where notices should be sent:

LORNA REID
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

Telephone number: H 914-633-5826 C 914-262-8726
Email Address: lorn1121@gmail.com

Name and address where payment should be sent (if different from above):

Telephone number: 914-633-5826
Email Address: lorn1121@gmail.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 (May 29, 2013): $ 93,174.35

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

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

If all or part of the claim arises from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business, pursuant to 11 U.S.C. § 503(b)(9), complete item 6.

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

2. Basis for Claim: _____
(See instruction #2)

3. Last four digits of any number by which creditor identifies Debtor: 0 8 8 4

3a. Debtor may have scheduled account as: _____ (See instruction #3a)

3b. Uniform Claim Identifier (optional): _____ (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 _____ **%** ☐ 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 part 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).

☐ 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).

☐ 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).

☐ Taxes or penalties owed to governmental units – 11 U.S.C. § 507 (a)(8).

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

☐ Other – Specify applicable paragraph of 11 U.S.C. § 507 (a)(__).

Amount entitled to priority:
$ 93,174.35

**Amounts are subject to adjustment on 4/1/16 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. Claim Pursuant to 11 U.S.C. § 503(b)(9): Indicate the amount of your claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim. $ _____

7. Credits. The amount of all payments on this claim has been credited for the purpose of making this proof of claim. (See instruction #7)

8. **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, and security agreements. [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. (*See instruction #8, 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: _____

9. **Signature:** (See instruction #9) 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: LORNA A REID (Signature) 9-12-2013 (Date)

Title: RN, MS

Company: Sound Shore Medical Center of Westchester

Address and telephone number (if different from notice address above):

_____

_____

_____

Telephone number: _____ 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 instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the Debtor, exceptions to these general rules may apply. 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. ANY PROOF OF CLAIM SUBMITTED BY FACSIMILE OR EMAIL WILL NOT BE ACCEPTED.

THE GENERAL BAR DATE IN THESE CHAPTER 11 CASES IS SEPTEMBER 16, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)
THE GOVERNMENTAL BAR DATE IN THESE CHAPTER 11 CASES IS NOVEMBER 25, 2013 AT 4:00 P.M. (PREVAILING EASTERN TIME)

Items to be completed in Proof of Claim Form

Court, Name of Debtor, and Case Number:
These chapter 11 cases were commenced in the United States Bankruptcy Court for the Southern District of New York on May 29, 2013 (the "Commencement Date"). You should select the Debtor against which you are asserting your claim.

A SEPARATE PROOF OF CLAIM FORM MUST BE FILED AGAINST EACH DEBTOR.

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. Please provide us with a valid email address. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount owed to the creditor on the Petition Date. Follow the instructions concerning whether to complete items 4, 5 and 6. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card. If the claim is based on delivering health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information. You may be required to provide additional disclosure if an interested party objects to your claim.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor: State only the last four digits of the Debtor's account or other number used by the creditor to identify the Debtor.

3a. Debtor May Have Scheduled Account As:
Report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the Debtor.

3b. Uniform Claim Identifier:
If you use a uniform claim identifier, you may report it here. A uniform claim identifier is an optional 24-character identifier that certain large creditors use to facilitate electronic payment in chapter 13 cases.

4. Secured Claim:
Check whether the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See Definitions.) If the claim is secured, check the box for the nature and value of property that secures the claim, attach copies of lien documentation, and state, as of the date of the bankruptcy filing, the annual interest rate (and whether it is fixed or variable), and the amount past due on the claim.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. § 507(a):
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Claim Pursuant to 11 U.S.C. § 503 (b)(9):
If you have a claim arising from the value of any goods received by the Debtor within 20 days before May 29, 2013, the date of commencement of the above cases, in which the goods have been sold to the Debtor in the ordinary course of the Debtor's business, state the amount of such claim and attach documentation supporting such claim. (See DEFINITIONS, below)

7. Credits:
An authorized signature on this proof of claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the Debtor credit for any payments received toward the debt.

8. Documents:
Attach redacted copies of any documents that show the debt exists and a lien secures the debt. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary in addition to the documents themselves. FRBP 3001(c) and (d). If the claim is based on delivering health care goods or services, limit disclosing confidential healthcare information. Do not send original documents, as attachments may be destroyed after scanning.

9. Date and Signature:
The individual completing this proof of claim must sign and date it. FRBP 9011. If the claim is filed electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what constitutes a signature. If you sign this form, you declare under penalty of perjury that the information provided is true and correct to the best of your knowledge, information, and reasonable belief. Your signature is also a certification that the claim meets the requirements of FRBP 9011(b). Whether the claim is filed electronically or in person, if your name is on the signature line, you are responsible for the declaration. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. If the claim is filed by an authorized agent, attach a complete copy of any power of attorney, and provide both the name of the individual filing the claim and the name of the agent. If the authorized agent is a servicer, identify the corporate servicer as the company. Criminal penalties apply for making a false statement on a proof of claim.

DEFINITIONS

Debtor
A Debtor is the person, corporation, or other entity that has filed a bankruptcy case.

Creditor
A creditor is the person, corporation, or other entity to whom the Debtor owes a debt that was incurred before the date of the bankruptcy filing. See 11 U.S.C. § 101(10).

Claim
A claim is the creditor's right to receive payment for a debt owed by the Debtor on the date of the bankruptcy filing. See 11 U.S.C. § 101(5). A claim may be secured or unsecured.

Proof of Claim
A proof of claim is a form used by the creditor to indicate the amount of the debt owed by the Debtor on the date of the bankruptcy filing. The creditor must file the form with GCG as described in the instructions above and in the Bar Date Notice.

Section 503(b)(9) Claim
A Section 503(b)(9) claim is a claim for the value of any goods received by the Debtor within 20 days before the date of commencement of a bankruptcy case in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business.

Secured Claim Under 11 U.S.C. § 506(a)
A secured claim is one backed by a lien on property of the Debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors. The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim. Examples of liens on property include a mortgage on real estate or a security interest in a car. A lien may be voluntarily granted by a Debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the Debtor money (has a right to setoff).

Unsecured Claim
An unsecured claim is one that does not meet the requirements of a secured claim. A claim may be partly unsecured if the amount of the claim exceeds the value of the property on which the creditor has a lien.

Claim Entitled to Priority Under 11 U.S.C. § 507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor must show only the last four digits of any social-security, individual's tax-identification, or financial-account number, only the initials of a minor's name, and only the year of any person's date of birth. If the claim is based on the delivery of health care goods or services, limit the disclosure of the goods or services so as to avoid embarrassment or the disclosure of confidential health care information.

INFORMATION

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

Acknowledgment of Filing of Claim
To receive a date-stamped copy of your proof of claim form, please provide a self-addressed stamped envelope and a copy of your proof of claim form when you submit the original to GCG. You will also receive an acknowledgment letter from GCG after your proof of claim form has been processed.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the Debtor. These entities do not represent the bankruptcy court or the Debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

Display of Proof of Claim on Case Administration Website
As the official claims agent, and in accordance with Federal Bankruptcy Rule 9037(g), GCG will display the first page of your proof of claim form on the case administration website. Please be aware that any personal information not otherwise redacted on your proof of claim form will be displayed over the Internet.

01001633
SSM0203341877

LORNA REID
15 SCHUDY PL
NEW ROCHELLE, NY 10801-2405

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 32 of 40

Name	Lorna A Reid	1001633 SSM0203341877
SS#	089-66-0884	
Employed By	Sound Shore Medical Center of Westchester	

Your Honor,

Also atatched is a copy of my 2013 accured Sick Time in hours equal to334.37 at hourly rate of $46.5120 amounting to $15,552.21

Copy of the 3% Temporary Salary Reduction Note which was scheduled for period July 2007 to January 2008. This Temporary Salary Reduction is still in effect to present date. Up until June 2013 I was not given a date when this 3% Temporery Salary Reduction will be refunded.

Respectfully Yours,

Lorna A. Reid RN. MS.
Performance Improvement Coordinator/Stroke Coordinator,
Sound Shore Medical Center of Westchester
16 Guion Place, New Rochelle, NY 10801
914-262-8726 ©
lorn1121@gmail.com

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 33 of 40

Name	Lorna A Reid	1001633 SSM0203341877	
SS#	089-66-0884		
Employed By	*Sound Shore Medical Center of Westchester*	*Chapter 11 Case. No. 13-22840 (RDD)*	
Date of Hire	06/04/1984 to present date.		
Address	15 Schudy Place, New Rochelle, NY 10801		
Phone	914-633-5826 (H) 914-262-8726 ©		
e-mail	lorn1121@gmail.com		

Sound Shore Medical Center of Westchester, et al
c/c GCG, Inc.
PO Bx. 9982
Dublin, OH 43017-5982

United States Bankruptcy Court For The Southern District Of New York

Your Honor,

Below represents my estimated Pension Fund that Sound Shore Medical Center of Westchester has not made any contributios towards from 2005 to present date

Year	Salary	Percentage Rate	Estimated Contribution
2005	$97,326.97	8.92%	$8,681.56
2006	$100,042.09	8.92%	$8,923.75
2007	$87,923.86	8.92%	$7,842.80
2008	$92,396.86	10.70%	$9,866.40
2009	$85,712.90	10.70%	$9,171.28
2010	$82,312.08	10.70%	$8,807.39
2011	$86,271.70	10.70%	$9,231.07
2012	$88,588.89	10.70%	$9,479.01
Jun-13	$52,326.00	10.70%	$5,598.88
			Total = $77,622.14

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 10) Pg 34 of 40

Name Lorna A Reid 01001633 SSM0203341877
SS# 089-66-0884
Employed By Sound Shore Medical Center of Westchester
Date of Hire 06/04/1984 to present date.
Address 15 Schudy Place, New Rochelle, NY 10801
Phone 914-633-5826 (H) 914-262-8726 ©
e-mail lorn1121@gmail.com

Chapter 11 Case. No. 13-22840 (RDD)

Sound Shore Medical Center of Westchester, et al
c/c GCG, Inc.
PO Bx. 9982
Dublin, OH 43017-5982

United States Bankruptcy Court For The Southern District Of New York

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Jun-13	$52,326.00	10.70%	$5,598.88
		Total =	$77,622.14

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

GCG #	Claim #	Filed Date	Creditor Name	Debtor Name	Total Scheduled Amount	Total Claimed Amount	Total Allowed Amount
1001633	748	09/16/13	LORNA REID	Sound Shore Medical Center of Westchester		$93,174.35 (Unliquidated)	
				Search Results Total	**$0.00**	**$93,174.35**	**$0.00**

The majority of claims, either filed or as set forth on the Debtors' Schedules of Assets and Liabilities, can be located through the Creditor Search. In addition, a Claims Register can be obtained by clicking the "Save as Excel" button. However, pursuant to an Order of the Bankruptcy Court dated March 12, 2013 [Docket No. 78], claim information for customers must be redacted to preserve confidentiality. Images for those claims will not be made available. If you have any questions regarding this case, please contact ssmTeam@gcginc.com

- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Medical Center of Westchester, et al.

Case Information Website

- Home
- Claims Register/ Creditor Search
- Client Login

Note: Claim information is subject to additional audit, review and revision.

Search By : Claim Number | Equal to | 748 | Find

Save As Excel

1 - 1 Of 1 Records

GCG #	Claim #	Filed Date	Creditor Name	Debtor Name	Total Scheduled Amount	Total Claimed Amount	Total Allowed Amount
1001633	748	09/16/13	LORNA REID	Sound Shore Medical Center of Westchester		$93,174.35 (Unliquidated)	
				Search Results Total	**$0.00**	**$93,174.35**	**$0.00**

The majority of claims, either filed or as set forth on the Debtors' Schedules of Assets and Liabilities, can be located through the Creditor Search. In addition, a Claims Register can be obtained by clicking the "Save as Excel" button. However, pursuant to an Order of the Bankruptcy Court dated March 12, 2013 [Docket No. 78], claim information for customers must be redacted to preserve confidentiality. Images for those claims will not be made available. If you have any questions regarding this case, please contact ssmTeam@gcginc.com

- Privacy Policy |
- © 2013 GCG |
- All Rights Reserved - ssm v1.0 (bnk 3.8.1) gcgo-jbprd3

Sound Shore Health System
Sound Shore Medical Center • The Mount Vernon Hospital • Schaffer Extended Care Center • Hopter School of Nursing

DATE: July 16, 2007

TO: DIRECTORS OF SERVICE
MEMBERS of MANAGEMENT COUNCIL

FROM: John R. Spicer

For the past few months, our healthcare system has been dealing with a difficult cash position. This has developed in large part from a lower than budgeted volume of services, and a less than budgeted case mix.

Our response has been to significantly reduce overtime and implement a limited restructuring plan. Now, a temporary salary reduction plan will occur from the first pay period in July to January 1, 2008. Those affected will be designated supervisory and managerial employees and salaried positions. This temporary salary reduction of 3% will allow the system to keep on track to achieve its patient care goals and minimize position reductions. We anticipate a cash turnaround by year end with the State's release of funds that are owed to both Sound Shore and Mount Vernon Hospitals.

I know you all understand our current situation, and I also know that we will continue to work collaboratively. In consideration of your support and dedication to SSHS, those experiencing this temporary salary reduction will be offered an additional five vacation days to be used before March 31, 2008.

Human Resources will follow up with more detail.

Thank you for your cooperation.

16 Guion Place • New Rochelle, NY 10802 • Tel: 914-632-5000 x 3700 • Fax: 914-637-1516
Member Pinnacle Healthcare

SOUND SHORE HEALTH SYSTEM
PAID TIME OFF REPORT

Employee Name: Linda Reid Position: _____ Date of Hire _____

YEAR

VACATION DAY Carried over from 2012 ____

	ACCRUED	TAKEN	AVAILABLE
January	132	—	132
February	132	—	132
March	132	7.5	124.5
April	132	—	132
May	132	15	117
June	132	—	132
July	132	15	117
August	132	15	117
September	132	15	117
October	132	15	117
November	132	15	117
December	132	15	117

HOLIDAY Carried over from 2012 ____

	ACCRUED	TAKEN	AVAILABLE
January	60	15	45
February	37.5	—	37.5
March	37.5	7.5	30
April	37.5	—	37.5
May	37.5	7.5	30
June	37.5	—	37.5
July	37.5	15	22.5
August	37.5	—	37.5
September	37.5	15	22.5
October	37.5	—	37.5
November	37.5	15	22.5
December	37.5	—	37.5

FREE Carried over from 2012 ____

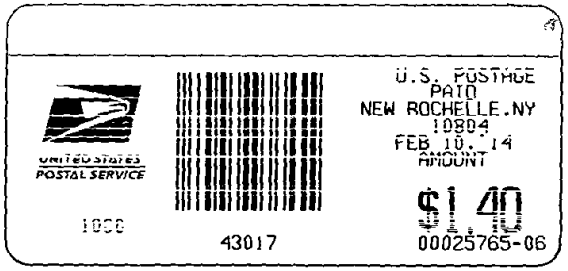
	ACCRUED	TAKEN	AVAI
January	30	2.5	22
February	22.5	—	22
March	22.5	—	22
April	22.5	—	22
May	22.5	—	22
June	22.5	—	22
July	22.5	15	7.5
August	22.5	—	22
September	22.5	—	22
October	22.5	—	22
November	22.5	—	22
December	22.5	—	22

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
January		14	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
February		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
March		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
April		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
May		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
June		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
July		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
August		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
September		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
October		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
November		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
December		D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

* BANK TIME***
VACATION:
HOLIDAY:
SICK:
FREE:

13-22840-rdd Doc 1139-12 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 10) Pg 38 of 40

Reed
Schady PC
New Rochelle
NY 10801



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

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)
Anna Maria Simpson

☐ 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 - 5 2014

Name and Addresses Where Notices Should be Sent
241 South 4th Ave
Apt 3K Mt Vernon N.Y
10580

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): Bonus / sick time

2. DATE DEBT WAS INCURRED (IF KNOWN)

3. DESCRIPTION OF CLAIM (IF KNOWN):

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):

_____ (Signature) _____ (Date)

Telephone number: 917-561-9309 email: Sunshine Anna 2 @ Hotmail.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 - 01361
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

13-22840-rdd Doc 1139-1 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Exhibit A (Part 10) Pg 40 of 40

From: Annth Simpson
26 South 9th Ave
Apt 31C
Mt Vernon N Y 10550

WESTCHESTER NY 105
28 JAN 2014 PM 6 T

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

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)
Transcare Ambulance

☐ 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. APR - 7 2014

Name and Address Where Notices Should be Sent:
Transcare Ambulance
One Metrotech Center- 20th Floor
Brooklyn NY 11201
Attention: Abraham Azar

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): 6/5/13 - 11/2/13

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 15,578.69 (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: Abraham Azar
Title: Supervisor Facility Billing
Company: Transcare Ambulance
Address and telephone number (if different from notice address above):

(Signature) 4/3/14 (Date)

Telephone number: 718-510-9105 email: AbrahamAzar@Transcare.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 - 01480
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YOR
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

TRANSCARE

To whom it may concern,

Transcare had not received any paperwork for to file a claim of open administrative claims. I have attached the emails that the invoices were sent to Soundshore and Mt Vernon Hospital in a timely manner but were never paid as per the post-Bankruptcy agreement. I have reached out numerous times to Soundshore but never received any information on who to contact until this week. If you have any question please feel free to reach out to me.

Thank you,

Abraham Azar

Supervisor, Facility Billing

Transcare Corporation

1 Metrotech Center - 20th Floor

Brooklyn NY, 11201

718-510-9105 Direct Line

347-689-7271 Fax

13-22840-rdd Doc 1139-13 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 11) Pg 3 of 39

Inv #	Patient Name	Srv.Date	From	To	#Trips	Amount
MET009611632	BARKER KRISTEN	6-14-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009616640	PICCO JAMES	6-28-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009618597	PACE ANGELO	7-03-2013	SOUNDSHORE MEDICAL CENTER	FISHKILL HEALTH RELATED CTR	2	1388.48
MET009622947	SANTILLAN JANET	7-16-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009629164	VALDEZ KATLYN	8-02-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009631937	RIQUELME ROSA	8-11-2013	SOUNDSHORE MEDICAL CENTER	JACOBI HOSPITAL	1	354.26
MET009635608	BARONE TRACY	8-22-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009636466	MARCIANTE CHIRSTOPHE	8-25-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009643325	ALLEN SHANA	9-14-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009646885	JOHNSON AUDLEY	9-24-2013	SOUNDSHORE MEDICAL CENTER	WESTCHESTER N.H.	1	275.78
MET009647377	CHISOLM ELIJAH	9-25-2013	SOUNDSHORE MEDICAL CENTER	Patient Residence	1	262.06
MET009649502	SOUNDSHORE SHUTTLE	10-02-2013	TRANSCARE AMBULANCE	SOUNDSHORE MEDICAL CENTER	1	9000.00
MET009654807	BARRAGAN REYES JUAN	10-16-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009658610	ZAPIEN PAOLA	10-28-2013	SOUNDSHORE MEDICAL CENTER	MOUNT VERNON HOSPITAL	1	275.78
MET009659623	NANCE RANDOLPH	10-30-2013	SOUNDSHORE MEDICAL CENTER	NEW ROCHELLE ADULT HOME	1	262.06
MET009660436	SOUNDSHORE SHUTTLE	11-02-2013	TRANSCARE AMBULANCE	SOUNDSHORE MEDICAL CENTER	1	300.00

FINAL BALANCE 14,324.66 #Inv 16 #Trip 17

13-22840-rdd Doc 1139-13 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 11) Pg 4 of 39

TCNY Statement of Account: Service date

Inv #	Patient Name	Srv.Date	From	To	#Trips	Amount
MET009608241	DEANELLIS LORETTA	6-05-2013	SOUNDSHORE MEDICAL CENTER	DUMONT MASONIC HOME	1	275.78
MET009608334	DEANELLIS LORETTA	6-05-2013	DUMONT MASONIC HOME	SOUNDSHORE MEDICAL CENTER	1	275.78
MET009627677	HUNTER JOHN	7-29-2013	SOUNDSHORE MEDICAL CENTER	WESTCHESTER CTR ASST LIV NUR	1	372.07
MET009633880	WRIGHT MONICA	8-16-2013	SOUNDSHORE MEDICAL CENTER	WARTBURG HOME	1	330.40

FINAL BALANCE 1,254.03 #Inv 4 #Trip 4

Abraham Azar

From: Abraham Azar
Sent: Monday, November 04, 2013 9:49 AM
To: 'jljuljic@sshsw.org'
Cc: 'Schoenherr, Kerri'; Jim O'Connor
Subject: November 2013 Shuttle Bill
Attachments: NRO Facility Billing Invoices.pdf; QPRTLTR.PDF

Importance: High

Tracking:

Recipient	Read
'jljuljic@sshsw.org'	
'Schoenherr, Kerri'	
Jim O'Connor	Read: 11/4/2013 10:03 AM

John,

Please see attached for the November 2013 Shuttle invoices as well as the post-bankruptcy Facility transports. Please try to release bill Facility invoices from June – September as they are already over 30 days past due. If you have any questions please let me know.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

Abraham Azar

From: Abraham Azar
Sent: Thursday, August 29, 2013 10:33 AM
To: 'Mamangakis, John' (jmamangakis@sshsw.org)
Cc: Jim O'Connor
Subject: Bill Facility Invoices
Attachments: QPRINT.PDF; QPRINT.PDF

John,

Please see attached for the bill Facility listings for Soundshore and Mt Vernon Hospital for June and July 2013 that was submitted previously. Please advise if they will be processed and paid timely according to the bankruptcy agreement.

Best regard and enjoy your labor day weekend,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

Abraham Azar

From: Abraham Azar
Sent: Wednesday, September 11, 2013 11:19 AM
To: 'Karounos, Rosa'
Cc: "Mamangakis, John' (jmamangakis@sshsw.org)'; Dave Dawson; Jim O'Connor
Subject: Soundshore Medical Center Bill Facility August 2013
Attachments: QPRTLTR.PDF

Rosa,

Please see attached for August 2013 invoices that were called in as bill Facility. These are not Inpatient Bundling claims. Please fax or email me the patients face sheets so I can either try to bill Insurance (if there is a valid authorization number). The system doesn't allow for me to include the date of birth in the invoice so I included it in the email. If you have any questions please let me know.

1.Valdez – 9/4/92
2.Riquelme – 4/30/75
3.Barone – 4/20/64
4.Marciante – 8/27/89

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Please Note New Fax Number

Abraham Azar

From: Abraham Azar
Sent: Monday, December 09, 2013 4:21 PM
To: 'AAlfano@montefiore.org'
Cc: Jim O'Connor; 'Schoenherr, Kerri'
Subject: November 2013 Facility Bills
Attachments: Montefiore New Rochelle November 2013.pdf

Anthony,

Please see attached for the November 2013 bill facility invoices. Please have them approved for payment and submitted to accounts payable. If you have any questions please let me know.

Also, I asked Kerri to find out for me if the NPI number for Soundshore (0274126) now has changed to Montefiore's number (0243554). This will make a difference in whether will be allowed to bill 3rd party insurance carriers for one way trips between the Montefiore facilities.

Thank you,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

Abraham Azar

From: Abraham Azar
Sent: Wednesday, January 08, 2014 2:53 PM
To: 'AAlfano@montefiore.org'
Cc: Jim O'Connor; 'Schoenherr, Kerri'
Subject: December 2013 Facility Bills
Attachments: QPRTLTR.PDF

Anthony,

Please see attached for the December 2013 bill facility invoices. Please have them approved for payment and submitted to accounts payable. If you have any questions please let me know.

Thank you and Happy New Year,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

Abraham Azar

From: Abraham Azar
Sent: Wednesday, October 02, 2013 10:57 AM
To: 'jljuljic@sshsw.org'
Cc: 'Schoenherr, Kerri'; Jim O'Connor
Subject: September & October 2013 Shuttle Bill
Attachments: NRO Facility Billing Invoices.pdf; NRO Facility Billing Invoices.pdf; QPRINT.PDF

John,

Please see attached for the September and October 2013 Shuttle invoices, as well as the post-bankruptcy Facility transports. Please try to release the September payment as soon as you can as well as the 4 bill Facility invoices from June and July. If you have any questions please let me know.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

Abraham Azar

From: Abraham Azar
Sent: Wednesday, September 11, 2013 1:51 PM
To: 'jljuljic@sshsw.org'
Subject: FW: Outstanding invoices
Attachments: QPRINT.PDF

John,

Jim O requested that I reach out to you as I have a couple of questions.

1. Should I be sending you the Monthly Shuttle ($9,000.00) invoice?
2. We have 4 post bankruptcy bill Facility transport claim from June and July that are still unpaid that I attached. Please advise on their status.

Best regards,

From: Jim O'Connor
Sent: Wednesday, September 11, 2013 12:41 PM
To: Abraham Azar; Jeff Koppel
Subject: FW: Outstanding invoices

Response from Sound Shore finance department

From: Jim O'Connor
Sent: Wednesday, September 11, 2013 12:40 PM
To: Ljuljic, John
Subject: RE: Outstanding invoices

John,
That would be great and much appreciated.....I would really like to have someone pick it up.....
Thanks again,
JO'C

From: Ljuljic, John [mailto:jljuljic@sshsw.org]
Sent: Wednesday, September 11, 2013 12:39 PM
To: Jim O'Connor
Subject: RE: Outstanding invoices

Jim by Friday

From: Jim O'Connor [mailto:jimo@transcare.com]
Sent: Wednesday, September 11, 2013 11:59 AM
To: Ljuljic, John
Cc: Schoenherr, Kerri; Abraham Azar
Subject: Outstanding invoices

John,

My name is Jim O'Connor and I am the President of TransCare Ambulance. Over the past 15 years, I have communicated with John Mamangakis pertaining to our service and invoices. Now that John has left, I've been directed to you. John Spicer can also fill you in on my longstanding relationship with SSMC. To that end, I am hoping I can send someone over today or tomorrow at the latest to pick up our payment of $9,000 for August transportation services which was promised to remain on time post the Ch 11 filing. Please call my cell so we may discuss 914-804-2550.
Thanks for your assistance with this matter.
Jim O'C

James O'Connor
President
TransCare Corporation
1 Metrotech Center, 20th Floor
Brooklyn, New York 11201
Office: (718) 510-9080

TransCare Corporation Confidentiality Note This E-mail message is intended to be received by persons entitled to receive the confidential information it may contain. Please do not Read, Copy, Forward or Save this message unless you are the intended recipient. If you have received this message in error, Please Forward it back to the Sender and Delete it completely from your computer system.

Checked: By Barracuda Spam and Virus Firewall

Abraham Azar

From: Abraham Azar
Sent: Tuesday, November 19, 2013 10:34 AM
To: 'Schoenherr, Kerri'
Subject: RE: Open Invoices through October 2013

Kerri,

Any update for me? Also, please advise on the check release for the October Shuttle if possible.

From: Abraham Azar.
Sent: Friday, November 15, 2013 9:29 AM
To: 'Schoenherr, Kerri'
Subject: Open Invoices through October 2013

Kerri,

As per our conversation please see attached listing of open bill facility transport claims post Bankruptcy. Please let me know when AP will be paying them.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Fax

-neutral
ping

Align top of FedEx Express® shipping label here.

ORIGIN ID:EGXA (718) 763-8888
ABRAHAM AZAR
TRANSCARE CORPORATION
1 METROTECH CENTER
20TH FLOOR
BROOKLYN, NY 11201
UNITED STATES US

SHIP DATE: 04APR14
ACTWGT: 1.0 LB MAN
CAD: 581585/CAFE2704

BILL THIRD PARTY

TO C/O CGC,INC
SOUNDSHORE MEDICAL CENTER
5151 BLAZER PARKWAY
SUITE A
DUBLIN OH 43017

REF:
INV:
PO: DEPT:

FedEx Express

TRK# 0201 4210 8370 6036

MON - 07 APR AA
STANDARD OVERNIGHT

SB OSUA

43017
OH-US LCK

Part # 156148-434 NRIT V3 01-10

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)
Transcare Ambulance

☐ 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. APR - 7 2014

Name and Addresses Where Notices Should be Sent:
Transcare Ambulance
one metro tech center- 20th Flor
Brooklyn NY 11201
Att: Abraham Azar

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): 7/13/13

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 385,54 (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: Abraham Azar
Title: Supervisor, Facility Billing
Company: Transcare Ambulance

(Signature) _____ (Date) 4/3/14

Address and telephone number (if different from notice address above):

Telephone number: 718 510 1805 email: Avin@Transcare.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 - 01481
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

TCNY Statement of Account: 1NR H M SCHAFFER EXT CARE NH PAGE -
Service date From To 11/05/13 DATE -

Inv #	Patient Name	Srv.Date	From	To	#Trips	Amount
MET009621763	CATALANO GLORIA	7-13-2013	SCHAFFER EXTENDED CARE	GRACE PLAZA NURSING HOME	1	385.54

FINAL BALANCE 385.54 #Inv 1 #Trip 1

utral

ORIGIN ID:EGXA (718) 763-8888
ABRAHAM AZAR
TRANSCARE CORPORATION
1 METROTECH CENTER
20TH FLOOR
BROOKLYN, NY 11201
UNITED STATES US

SHIP DATE: 04APR14
ACTWGT: 1.0 LB MAN
CAD: 581585/CAFE2704

BILL THIRD PARTY

TO **C/O CGC,INC**
SOUNDSHORE MEDICAL CENTER
5151 BLAZER PARKWAY
SUITE A
DUBLIN OH 43017

REF:
INV:
PO: DEPT:

FedEx Express

J131113052301 26

MON - 07 APR AA
STANDARD OVERNIGHT

TRK# 0201 **4210 8370 6036**

SB OSUA

43017
OH-US **LCK**

Ref # 156143-434 NEAT V8.01-10

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)
Transcare Ambulance

☐ 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. APR - 7 2014

Name and Addresses Where Notices Should be Sent:
Transcare Ambulance
one metrotech Center 20th flor
Brooklyn NY 11201
Attention: Abraham Azar

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): 8/14/13 - 11/1/13

3. DESCRIPTION OF CLAIM (IF KNOWN):

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 1,488.66 (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: Abraham Azar
Title: Supervisor Facility Billing
Company: Transcare Ambulance

(Signature) _____ (Date) 4/3/14

Address and telephone number (if different from notice address above):

Telephone number: 718 510-9105 email: Avia@Transcare.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

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FILED - 01482
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

TRANSCARE

The Driving Force in Health Care

To whom it may concern,

Transcare had not received any paperwork for to file a claim of open administrative claims. I have attached the emails that the invoices were sent to Soundshore and Mt Vernon Hospital in a timely manner but were never paid as per the post-Bankruptcy agreement. I have reached out numerous times to Soundshore but never received any information on who to contact until this week. If you have any question please feel free to reach out to me.

Thank you,

Abraham Azar

Supervisor, Facility Billing

Transcare Corporation

1 Metrotech Center - 20th Floor

Brooklyn NY, 11201

718-510-9105 Direct Line

347-689-7271 Fax

13-22840-rdd Doc 1139-13 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 11) Pg 20 of 39

TCNY Statement of Account: MVN MT VERNON HOSPITAL PAGE -
Service date From To 11/05/13 DATE -

Inv #	Patient Name	Srv.Date	From	To	#Trips	Amount
MET009633142	STANLEY IESHSA	8-14-2013	MOUNT VERNON HOSPITAL	CHAM CHILDRENS HOSP AT MTF	1	289.50
MET009642709	STEVENS JAMES	9-12-2013	MOUNT VERNON HOSPITAL	DUMONT MASONIC HOME	1	289.50
MET009649418	PATRICK ISABELLA	10-01-2013	MOUNT VERNON HOSPITAL	Patient Residence	1	262.06
MET009653259	DESILVA ANDREW	10-11-2013	MOUNT VERNON HOSPITAL	NEW YORK PRESBYTERIAN PSY UNIT	1	344.38
MET009660408	NELSON DERRICK	11-01-2013	MOUNT VERNON HOSPITAL	JACOBI HOSPITAL BX MUNICIPAL	1	303.22

FINAL BALANCE 1,488.66 #Inv 5 #Trip 5

Abraham Azar

From: Abraham Azar
Sent: Wednesday, September 11, 2013 11:14 AM
To: 'ntighe@sshsw.org' (ntighe@sshsw.org)
Cc: Dave Dawson
Subject: August 2013 Bill
Attachments: QPRTLTR.PDF

Nuala,

Please see attached for the August 2013 invoices. We haven't received any payments on the post bankruptcy invoices to date. Can you please follow up with Nick and advise.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Please Note New Fax Number

Abraham Azar

From: Abraham Azar
Sent: Monday, October 07, 2013 4:43 PM
To: 'ntighe@sshsw.org' (ntighe@sshsw.org)
Cc: Dave Dawson
Subject: September 2013 Bill
Attachments: QPRTLTR.PDF

Nuala,

Please see attached for the September 2013 invoices. I am happy to say we have received the payment for the June and July invoices.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Please Note New Fax Number

Abraham Azar

From: Abraham Azar
Sent: Friday, November 08, 2013 1:25 PM
To: 'ntighe@sshsw.org' (ntighe@sshsw.org)
Cc: Dave Dawson
Subject: October 2013 Bill
Attachments: QPRTLTR.PDF

Nuala,

Please see attached for the October 2013 invoices.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Please Note New Fax Number

Abraham Azar

From: Abraham Azar
Sent: Monday, December 09, 2013 4:41 PM
To: 'ntighe@sshsw.org' (ntighe@sshsw.org)
Cc: Dave Dawson
Subject: November 2013 Bill
Attachments: MVN INV.pdf

Nuala,

Please see attached for the November 2013 invoice.

Best regards,

Abraham Azar
Supervisor, Facility Billing
Transcare Corporation
1 Metrotech Center - 20th Floor
Brooklyn NY, 11201
718-510-9105 Direct Line
347-689-7271 Please Note New Fax Number

Affix top of FedEx Express® shipping label here

utral

ORIGIN ID:EGXA (718) 763-8888
ABRAHAM AZAR
TRANSCARE CORPORATION
1 METROTECH CENTER
20TH FLOOR
BROOKLYN, NY 11201
UNITED STATES US

SHIP DATE: 04APR14
ACTWGT: 1.0 LB MAN
CAD: 581585/CAFE2704

BILL THIRD PARTY

TO **C/O CGC,INC**
SOUNDSHORE MEDICAL CENTER
5151 BLAZER PARKWAY
SUITE A
DUBLIN OH 43017

REF:
INV:
PO: DEPT:

FedEx Express

J131113052301 26

MON - 07 APR AA
STANDARD OVERNIGHT

TRK# 0201 **4210 8370 6036**

SB OSUA

43017
OH-US **LCK**

Part # 156148-434 NAR V3.01-10

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)
TURIANO JOAN

☐ 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 28 2014

Name and Addresses Where Notices Should be Sent:
342 UNION AVE
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) GRANDFATHER PENSION

2. DATE DEBT WAS INCURRED (IF KNOWN):

3. DESCRIPTION OF CLAIM (IF KNOWN) GRANDFATHER PENSION

FILED - 01470
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 48,420.13 (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: JOAN TURIANO
Title: MATERIALS SPECIALIST - PURCHASING
Company: SOUND SHORE MED CTR OF WESTCHESTER
(Signature) (Date)
Address and telephone number (if different from notice address above):

Telephone number 914 406 9544 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.

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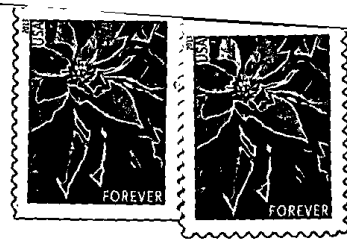
JOAN TURIANO - 090446

DATE				BALANCE
				$ 104,910.41
02/23/13			$ 4,035.02	$ 100,875.39
03/09/13			$ 4,035.02	$ 96,840.37
03/23/13			$ 4,035.02	$ 92,805.35
04/06/13			$ 4,035.02	$ 88,770.33
04/20/13			$ 4,035.02	$ 84,735.31
05/04/13			$ 4,035.02	$ 80,700.29
05/18/13			$ 4,035.02	$ 76,665.27
06/01/13			$ 4,035.02	$ 72,630.25
06/15/13			$ 4,035.02	$ 68,595.23
06/29/13			$ 4,035.02	$ 64,560.21
07/13/13			$ 4,035.02	$ 60,525.19
07/27/13			$ 4,035.02	$ 56,490.17
08/10/13			$ 4,035.02	$ 52,455.15
08/24/13			$ 4,035.02	$ 48,420.13
09/07/13				$ 48,420.13
09/21/13				$ 48,420.13
10/05/13				$ 48,420.13
10/19/13				$ 48,420.13
11/02/13				$ 48,420.13
11/16/13				$ 48,420.13
11/30/13				$ 48,420.13
12/14/13				$ 48,420.13
12/28/13				$ 48,420.13
01/11/14				$ 48,420.13
01/25/14				$ 48,420.13
02/08/14				$ 48,420.13

13-22840-rdd Doc 1139-13 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 11) Pg 28 of 39

342 Union Ave
New Rochelle NY
10801

POSTAGE
DUE $.21



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

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)

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[ ] 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)
UnitedHealthcare/Executive Health Resources, 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.

THE GARDEN CITY GROUP, INC. FEB - 3 2014

Name and Addresses Where Notices Should be Sent:
Rachel A. Smith, CDM, UHC
Bankruptcy Legal Services Specialist
185 Asylum Street ~ 3rd Floor ~ 03B
Hartford, CT 06103
860.702 7091 | rasmith@uhc.com

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: SHS-SoundShore

1. BASIS FOR CLAIM:
[ ] Goods sold [X] 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): 5/29/13 - 11/6/13

3. DESCRIPTION OF CLAIM (IF KNOWN):
Medical necessity reviews & related compliance consulting services

FILED - 01359
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 22,438 79 (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
[X] 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: Rachel A Smith
Title: Bankruptcy Legal Services Specialist
Company: UHC/Executive Health Resources, Inc.
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: _____ email: _____

Rachel A Smith (Signature) 1/29/2014 (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.

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UnitedHealthcare®

Rachel A. Smith
Credit & Delinquency Management
185 Asylum Street ~ 03B
Hartford, CT 06115-0450
Telephone: (860) 702-7091
Facsimile: (860) 702-8870

January 30, 2014

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

Re: Sound Shore Medical Center of Westchester, et al
Chpt. 11 Bankruptcy filed 5/29/13 | Lead Case No. 13-22840

Dear Claims Processor:

Enclosed please find the following executed Administrative Proof of Claims regarding debt outstanding of the above-referenced debtors and a jointly filed case, being due United Healthcare Insurance Company/Executive Health Resources, Inc.

CASE NAME	ASSOCIATED CASE NO.	CLAIM AMOUNT
Sound Shore Medical Center of Westchester	13-22840	$22,438.79
The Mount Vernon Hospital, Inc.	13-22841	$5,127.50

Kindly file and return stamped copies of these claims to my attention in the self-addressed pre-paid envelope enclosed for your convenience.

Your prompt anticipated cooperation in this matter is greatly appreciated.

Should you have any questions or concerns in the meantime, please do not hesitate to contact me.

Thank you.

Cordially yours,

Rachel A. Smith
Bankruptcy Legal Services Specialist
Credit & Delinquency Management

/RAS
Enclosures
(Overnight Mail No. 1ZR8473F0190009224)

13-22840-rdd Doc 1139-13 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims (Part 11) Pg 31 of 39

EHR®
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company™

Sound Shore Medical Center
Attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801
EHRic ID: SSHS-SoundShore

Date: 1/29/14

Invoice Number	Invoice Detail	Invoice or Payment Post Date	Due Date	Fees	Payment Date	Payment Amount	Payment ID	Running Balance	Notes	Post-Petition Pre-Sale Determination	Fees	Post-Petition Pre-Sale Portion 5/29/13 - 11/6/13
80918	May 2013 - Implementation Fee	5/31/2013	7/7/2013	$ 2,500.00	No Payments			$ 2,500.00	Invoice relates solely to 5/1/13 - 5/31/13 activity, Pro-rate entire invoice amount (below)		$ 2,500.00	$ 161.29
96344	May 2013 Services	5/31/2013	7/7/2013	$ 4,875.00				$ 7,375.00	Invoice relates solely to 5/1/13 - 5/31/13 activity, Pro-rate entire invoice amount (below)		$ 4,875.00	$ 314.52
Payment					7/8/2013	$ (314.52)	Check No 7036023	$ 7,060.48	Payment applied to Invoice No 96344 per debtor's request; Invoice previously pro-rated below		$ (314.52)	$ (314.52)
101575	July 2013 Services	7/31/2013	9/6/2013	$ 6,575.00	No Payments			$ 13,635.48	Invoice relates solely to 7/1/13 - 7/31/13 activity, Entire invoice is post-petition pre-sale		$ 6,575.00	$ 6,575.00
104214	August 2013 Services	8/31/2013	10/9/2013	$ 7,560.00				$ 21,195.48	Invoice relates solely to 8/1/13 - 8/31/13 activity, Entire invoice is post-petition pre-sale		$ 7,560.00	$ 7,560.00
106903	Sept 2013 Services	9/30/2013	11/6/2013	$ 345.00				$ 21,540.48	Invoice relates solely to 9/1/13 - 9/30/13 activity, Entire invoice is post-petition pre-sale		$ 345.00	$ 345.00
109662	October 2013 Services	10/31/2013	12/7/2013	$ 7,555.00				$ 29,095.48	Invoice relates solely to 10/1/13 - 10/31/13 activity, Entire invoice is post-petition pre-sale		$ 7,555.00	$ 7,555.00
112397	November 2013 Services	11/30/2013	1/5/2014	$ 1,455.00				$ 30,550.48	Invoice relates solely to 11/1/11 - 11/30/11 activity, Pro-rate entire invoice amount (below)		$ 1,455.00	$ 242.50
TOTALS				$ 28,365.00		$ (314.52)	BALANCE		Total balance due EHR, valid due & owing		$ 30,550.48	$ 22,438.79

PRE-SALE PRO-RATION

Sound Shore Medical Center of Westchester
Chpt. 11 Bankruptcy filed 5/29/13

Admin Expense Time Frame: 5/29/13 thru 11/6/13

Invoice No. 80918 | $2,500

$2,500 (Entire invoice amount) ÷ 31 (# days in May) = $80.65 Fee per diem
$80.65 (Fee Per Diem) X 2 (# days after filing) = **$161.29 Total Post-petition Admin Expense**

Invoice No. 96344 | $4,875

$4,875 (Entire Invoice amount) ÷ 31 (# days in May) = $157.26 Fee per diem
$157.26 (Fee Per Diem) X 2 (# days after filing) = **$314.52 Total Post-petition Admin Expense**

Invoice No. 112397 | $1,455

$1,455 (Entire invoice amount) ÷ 30 (# days in Nov) = $48.50 Fee per diem
$48.50 (Fee Per Diem) X 5 (# days before sale) = **$242.50 Total Pre-sale Post-petition Admin Expense**

EHR®
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company™

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073

P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
5/31/2013	80918

Service

May 2013 - Implementations

Bill To

Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	7/7/2013

Service	QTY	Rate	Amount
May 2013 - Implementations			
Implementation Fee - May 2013		2,500.00	2,500.00

Please Remit To:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia, PA 19182-2688

Total	**$2,500.00**
Payments/Credits	$0.00
Balance Due	**$2,500.00**

Billing Questions?
Please call 484-362-1762 or e-mail ar@ehrdocs.com.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
5/31/2013	96344

Service
May 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	7/7/2013

Service	QTY	Rate	Amount
System Group Volume: 2,730 Facility Volume Received: 15			
EHR Services - RAC Redetermination Appeals	1	$325.00	$325.00
EHR Coding Government Denial Review	14	$325.00	$4,550.00
		Total	**$4,875.00**
		Payments/Credits	
		Balance Due	**$4,875.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
7/31/2013	101575

Service
July 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	9/6/2013

Service	QTY	Rate	Amount
System Group Volume: 3,599 Facility Volume Received: 20			
EHR Services - RAC Discussion Appeals	1	$325.00	$325.00
EHR Services - RAC Redetermination Appeals	16	$325.00	$5,200.00
EHR Coding Government Denial Review	3	$325.00	$975.00
Postage Expense Reimbursement - $5 per Retro Appeal	15	$5.00	$75.00

Total	$6,575.00
Payments/Credits	
Balance Due	$6,575.00

Billing Questions? Please call 484-362-1762 or email ar@ehrdocs.com

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
8/31/2013	104214

Service
August 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	10/9/2013

Service	QTY	Rate	Amount
System Group Volume: 3,816			
Facility Volume Received: 23			

EHR Services - RAC Discussion Appeals	2	$325.00	$650.00
EHR Services - RAC Redetermination Appeals	11	$325.00	$3,575.00
EHR Coding Government Denial Review	10	$325.00	$3,250.00
Postage Expense Reimbursement - $5 per Retro Appeal	17	$5.00	$85.00
Total			**$7,560.00**
Payments/Credits			
Balance Due			**$7,560.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
9/30/2013	106903

Service
September 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	11/6/2013

Service	QTY	Rate	Amount
System Group Volume: 1 Facility Volume Received: 1			
EHR Services - RAC Discussion Appeals	1	$325.00	$325.00
Postage Expense Reimbursement - $5 per Retro Appeal	4	$5.00	$20.00

Total	**$345.00**
Payments/Credits	
Balance Due	**$345.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
10/31/2013	109662

Service
October 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	12/7/2013

Service	QTY	Rate	Amount
System Group Volume: 12			
Facility Volume Received: 12			

EHR Services - RAC Discussion Appeals	1	$325.00	$325.00
EHR Services - RAC Redetermination Appeals	11	$325.00	$3,575.00
EHR Services - RAC ALJ Appeals (With Prior EHR Review)	8	$450.00	$3,600.00
Postage Expense Reimbursement - $5 per Retro Appeal	11	$5.00	$55.00
Total			**$7,555.00**
Payments/Credits			
Balance Due			**$7,555.00**

* *Some Incomplete cases referred in previous months are included on this invoice. Additional information available upon request.*

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
11/30/2013	112397

Service
November 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Sound Shore Medical Center
attn: Rhonda Ruiz
16 Guion Place
New Rochelle, NY 10801

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-SoundShore		Net 30	1/5/2014

Service	QTY	Rate	Amount
System Group Volume: 1 Facility Volume Received: 1			
EHR Services - RAC Redetermination Appeals	1	$325.00	$325.00
EHR Services - RAC ALJ Appeals (With Prior EHR Review)	2	$450.00	$900.00
Postage Expense Reimbursement - $5 per Retro Appeal	46	$5.00	$230.00
Total			**$1,455.00**
Payments/Credits			
Balance Due			**$1,455.00**

* *Some Incomplete cases referred in previous months are included on this invoice. Additional information available upon request.*

UPS CampusShip: View/Print Label

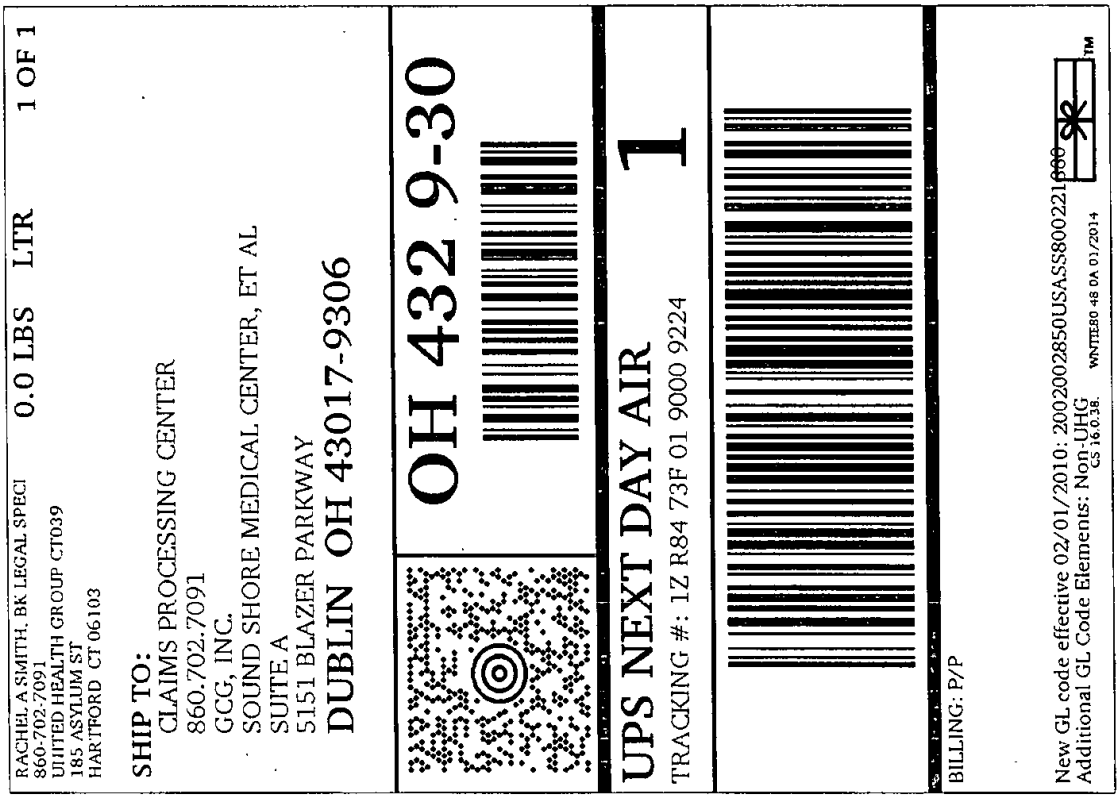
1. **Ensure there are no other shipping or tracking labels attached to your package.** Select the Print button on the print dialog box that appears. Note: If your browser does not support this function select Print from the File menu to print the label.

2. **Fold the printed sheet containing the label at the line so that the entire shipping label is visible. Place the label on a single side of the package and cover it completely with clear plastic shipping tape. Do not cover any seams or closures on the package with the label.** Place the label in a UPS Shipping Pouch. If you do not have a pouch, affix the folded label using clear plastic shipping tape over the entire label.

3. **GETTING YOUR SHIPMENT TO UPS**
   UPS locations include the UPS Store®, UPS drop boxes, UPS customer centers, authorized retail outlets and UPS drivers.
   Schedule a same day or future day Pickup to have a UPS driver pickup all your CampusShip packages.
   Hand the package to any UPS driver in your area.
   Take your package to any location of The UPS Store®, UPS Drop Box, UPS Customer Center, UPS Alliances (Office Depot® or Staples®) or Authorized Shipping Outlet near you. Items sent via UPS Return Services(SM) (including via Ground) are also accepted at Drop Boxes. To find the location nearest you, please visit the Resources area of CampusShip and select UPS Locations.

   Customers with a Daily Pickup
   Your driver will pickup your shipment(s) as usual.

FOLD HERE



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)
UnitedHealthcare/Executive Health Resources, 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.

THE GARDEN CITY GROUP, INC. FEB - 3 2014

Name and Addresses Where Notices Should be Sent:
Rachel A Smith, CDM, UHC
Bankruptcy Legal Services Specialist
185 Asylum Street ~ 3rd Floor ~ 03B
Hartford, CT 06103
860 702 7091 | rasmith@uhc.com

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:
SSHS-MtVernon

FILED - 01358
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

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): 5/29/13 - 11/6/13

3. DESCRIPTION OF CLAIM (IF KNOWN):
Medical necessity reviews & related compliance consulting services

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 5,127 50 (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: Rachel A. Smith
Title: Bankruptcy Legal Services Specialist
Company: UHC/Executive Health Resources, Inc.
Address and telephone number (if different from notice address above):

Rachel A Smith 1/29/2014
(Signature) (Date)

Telephone number: _____ 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.

UnitedHealthcare®

Rachel A. Smith
Credit & Delinquency Management
185 Asylum Street ~ 03B
Hartford, CT 06115-0450
Telephone: (860) 702-7091
Facsimile: (860) 702-8870

January 30, 2014

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

Re: Sound Shore Medical Center of Westchester, et al
Chpt. 11 Bankruptcy filed 5/29/13 | Lead Case No. 13-22840

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CASE NAME	ASSOCIATED CASE NO.	CLAIM AMOUNT
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The Mount Vernon Hospital, Inc.	13-22841	$5,127.50

Kindly file and return stamped copies of these claims to my attention in the self-addressed pre-paid envelope enclosed for your convenience.

Your prompt anticipated cooperation in this matter is greatly appreciated.

Should you have any questions or concerns in the meantime, please do not hesitate to contact me.

Thank you.

Cordially yours,

Rachel A. Smith
Bankruptcy Legal Services Specialist
Credit & Delinquency Management

/RAS
Enclosures
(Overnight Mail No. 1ZR8473F0190009224)

13-22840-rdd Doc 1139-14 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 12) Pg 3 of 24

EHR®
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company™

Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550
EHRic ID: SSHS-MtVernon

Date: 1/29/14

Invoice Number	Invoice Detail	Invoice or Payment Post Date	Due Date	Fees	Payment Date	Payment Amount	Payment ID	Running Balance	Notes	Post-petition Pre-sale Determination	Fees	Post-petition Pre-sale Portion 5/29/13 - 11/6/13
101724	August 2013 Implementation	8/31/2013	10/9/2013	$ 2,500.00				$ 2,500.00	Invoice relates solely to 8/1/13 - 8/31/13 activity; Entire invoice is post-petition pre-sale		$ 2,500.00	$ 2,500.00
104215	August 2013 Services	8/31/2013	10/9/2013	$ 2,600.00				$ 5,100.00	Invoice relates solely to 8/1/13 - 8/31/13 activity; Entire invoice is post-petition pre-sale		$ 2,600.00	$ 2,600.00
106904	September 2013 Services	9/30/2013	11/6/2013	$ 5.00	No Payments			$ 5,105.00	Invoice relates solely to 9/1/13 - 9/30/13 activity; Entire invoice is post-petition pre-sale		$ 5.00	$ 5.00
109663	October 2013 Services	10/31/2013	12/7/2013	$ 20.00				$ 5,125.00	Invoice relates solely to 101/13 - 10/31/13 activity, Entire invoice is post-petition pre-sale		$ 20.00	$ 20.00
112398	November 2013 Services	11/30/2013	1/5/2014	$ 15.00				$ 5,140.00	Invoice relates solely to 11/1/11 - 11/30/11 activity, Pro-rate entire invoice amount (below)		$ 15.00	$ 2.50
TOTALS				$ 5,140.00	$ 0.00		BALANCE	$ 5,140.00	Total balance due EHR, valid due & owing		$ 5,140.00	$ 5,127.50

PRE-SALE PRO-RATION

Sound Shore Medical Center of Westchester, et al
Chpt. 11 Bankruptcy filed 5/29/13

"Mount Vernon Chpt. 11 Case No. 13-22841"

Admin Expense Timeframe: 5/29/13 - 11/6/13

Invoice No. 112398 | $15.00

$15.00 (Entire invoice amount) ÷ 30 (# days in November) = $0.50 Fee per diem
$0.50 (Fee Per Diem) X 5 (# days before sale) = **$2.50 Total Pro-rated Pre-sale Post-petition Admin Expense**

EHR®
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company™

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073

P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
8/31/2013	101724

Service

August 2013 - Implementations

Bill To

Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-MtVernon		Net 30	10/9/2013

Service	QTY	Rate	Amount
August 2013 - Implementations			
Implementation Fee - August 2013 - Implementations		2,500.00	2,500.00

Please Remit To:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia, PA 19182-2688

Total	**$2,500.00**
Payments/Credits	$0.00
Balance Due	**$2,500.00**

Billing Questions?
Please call 484-362-1762 or e-mail ar@ehrdocs.com.

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
8/31/2013	104215

Service
August 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-MtVernon		Net 30	10/9/2013

Service	QTY	Rate	Amount
System Group Volume: 3,816 Facility Volume Received: 8			
EHR Services - RAC Redetermination Appeals	8	$325.00	$2,600.00
Total			**$2,600.00**
Payments/Credits			
Balance Due			**$2,600.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
9/30/2013	106904

Service
September 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-MtVernon		Net 30	11/6/2013

Service	QTY	Rate	Amount
System Group Volume: 1 Facility Volume Received: 0 ----------			
Postage Expense Reimbursement - $5 per Retro Appeal	1	$5.00	$5.00
Total			**$5.00**
Payments/Credits			
Balance Due			**$5.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
10/31/2013	109663

Service
October 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-MtVernon		Net 30	12/7/2013

Service	QTY	Rate	Amount
System Group Volume: 12 Facility Volume Received: 0			
Postage Expense Reimbursement - $5 per Retro Appeal	4	$5.00	$20.00
Total			**$20.00**
Payments/Credits			
Balance Due			**$20.00**

EHR
EXECUTIVE HEALTH RESOURCES
The Physician Advisor Company®

15 Campus Boulevard
Suite 200
Newtown Square, PA 19073
P: 610-446-6100
F: 610-446-6860

Invoice

Date	Invoice #
11/30/2013	112398

Service
November 2013

PLEASE REMIT TO:
Executive Health Resources, Inc
P.O. Box 822688
Philadelphia PA 19182-2688

Bill To
Mount Vernon Hospital
12 North Seventh Avenue
Mount Vernon, NY 10550

EHRiC ID	Hospital PO	Terms	Due Date
SSHS-MtVernon		Net 30	1/5/2014

Service	QTY	Rate	Amount
System Group Volume: 1 Facility Volume Received: 0			
Postage Expense Reimbursement - $5 per Retro Appeal	3	$5.00	$15.00
Total			**$15.00**
Payments/Credits			
Balance Due			**$15.00**

UPS CampusShip: View/Print Label

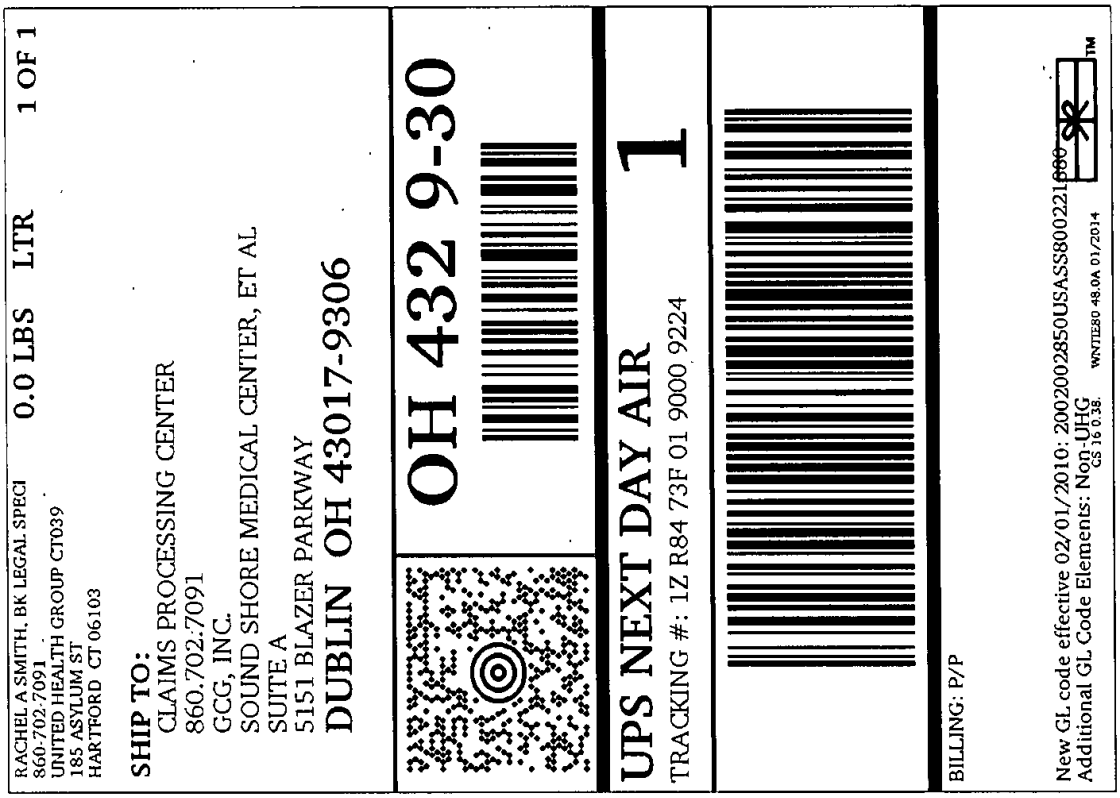
1. **Ensure there are no other shipping or tracking labels attached to your package.** Select the Print button on the print dialog box that appears. Note: If your browser does not support this function select Print from the File menu to print the label.

2. **Fold the printed sheet containing the label at the line so that the entire shipping label is visible. Place the label on a single side of the package and cover it completely with clear plastic shipping tape. Do not cover any seams or closures on the package with the label.** Place the label in a UPS Shipping Pouch. If you do not have a pouch, affix the folded label using clear plastic shipping tape over the entire label.

3. **GETTING YOUR SHIPMENT TO UPS**
   UPS locations include the UPS Store®, UPS drop boxes, UPS customer centers, authorized retail outlets and UPS drivers.
   Schedule a same day or future day Pickup to have a UPS driver pickup all your CampusShip packages.
   Hand the package to any UPS driver in your area.
   Take your package to any location of The UPS Store®, UPS Drop Box, UPS Customer Center, UPS Alliances (Office Depot® or Staples®) or Authorized Shipping Outlet near you. Items sent via UPS Return Services(SM) (including via Ground) are also accepted at Drop Boxes. To find the location nearest you, please visit the Resources area of CampusShip and select UPS Locations.

   Customers with a Daily Pickup
   Your driver will pickup your shipment(s) as usual.

FOLD HERE



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)
United Steel Products, Inc

Name and Addresses Where Notices Should be Sent:
33-40 127th place
Flushing, NY 11368

☐ 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.

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

Claim Number (if known): _____

Dated: _____

THE GARDEN CITY GROUP, INC. FEB - 7 2014

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): 8/27/13

3. DESCRIPTION OF CLAIM (IF KNOWN): Repaired fire proof door

FILED - 01363
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 420.00 (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: Alfredo FRANZA
Title: Vice President
Company: United Steel Products, Inc
Address and telephone number (if different from notice address above):

(Signature) 1/31/14 (Date)

Telephone number: 718-478-5330 email: AlFranza@UnitedSteelProducts.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.

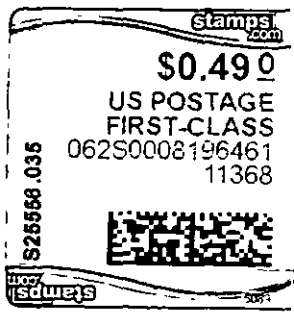
INSTRUCTIONS FOR PROOF OF CLAIM FORM

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.

13-22840-rdd Doc 1139-14 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 12) Pg 11 of 24

UNITED STEEL PRODUCTS, INC.
33-40 127TH PLACE
FLUSHING, NEW YORK 11368-1508



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

43017598282

FILED - 01348
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WEST CHESTER
ROBERT D. DRAIN

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)
VANDIS 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.

THE GARDEN CITY GROUP, INC. FEB - 3 2014

Name and Addresses Where Notices Should be Sent:
VANDIS INC.
1 ALBERTSON AVE., SUITE 1
ALBERTSON, NY 11507

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: CUSTOMER NO. SOUNDSH

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): 07/25/2013

3. DESCRIPTION OF CLAIM (IF KNOWN): GOODS SOLD (ARUBA SUPPORT RENEWAL)

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 12,279.75 (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: SCOTT RATAFIA
Title: CONTROLLER
Company: VANDIS INC.
Address and telephone number (if different from notice address above):

(Signature) (Date) 01/29/2014

Telephone number: 516-281-2200 email: SRATAFIA@VANDIS.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

1 Albertson Ave.
Suite 1
Albertson, NY 11507
(516) 281-2200

INVOICE

SOLD TO:
Sound Shore Medical Center
16 Guion Place
Attn: Accounts Payable
New Rochelle, NY 10802

CONFIRM TO:

INVOICE NUMBER: 0035698-IN
INVOICE DATE: 07/25/2013

ORDER NUMBER: 0022805
ORDER DATE: 07/19/2013
SALESPERSON: 0029
CUSTOMER NO: SOUNDSH

SHIP TO:

Sound Shore Medical Center

16 Guion Place
Attn: Francis Hall
PO#: NR177962
New Rochelle, NY 10801

CUSTOMER P.O.	SHIP VIA	F.O.B.	TERMS
NR177962	EMAIL		Net 15 Davs

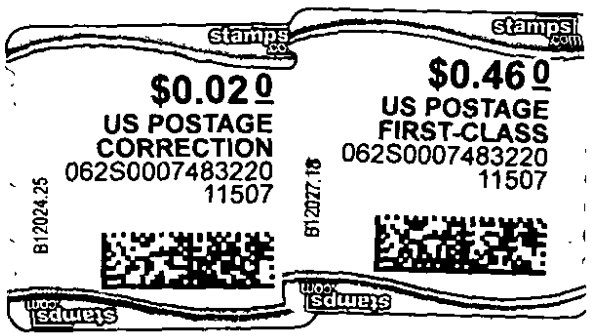
ITEM NO.	UNIT	ORDERED	SHIPPED	BACK ORD	PRICE	AMOUNT
SUPPSYSTEMR Aruba Support Renewal	EACH	1.00 WHSE: 000	1.00	0.00	12,279.75	12,279.75

Net Invoice:	12.279.75
Less Discount:	0.00
Freight:	0.00
Sales Tax:	0.00
Invoice Total:	**12,279.75**
Less Deposit:	0.00
Invoice Balance:	**12,279.75**

Please remit to:
Vandis
PO Box 826118
Philadelphia PA 19182-6118

13-22840-rdd Doc 1139-14 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
Pg 14 of 24

1 Albertson Ave. • Albertson, NY 11507



SOUNT SHORE MEDICAL OF WESTCHESTER
et al., 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)
DENISE M. WYCHE

☐ 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. APR - 3 2014

Name and Addresses Where Notices Should be Sent:
DENISE M. WYCHE
80 GUION PL APT 12W
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): BETWEEN MAY 29, 2013 AND NOVEMBER 6, 2013

3. DESCRIPTION OF CLAIM (IF KNOWN): PENSION - NO CONTRIBUTION

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 3,853.82 (Total)
SEE ATTACHED BREAK DOWN/CALCULATION

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: DENISE M. WYCHE
Title: _____
Company: _____
Address and telephone number (if different from notice address above):
_____
_____
_____
Telephone number: (914) 576-9844

(Signature) Denise M. Wyche (Date) 1/16/2014

email: dwyche@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.

FILED - 01479
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YOR
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D DRAIN

United States Bankruptcy Court, SDNY
300 Quarropas Street
White Plains, NY 10601
Attention: Clerk Of the Court

Re: Chapter 11 Case # 13-22840
Administrative Expense Proof of Claim
Denise M. Wyche - Date of Hire 1/8/1975

Pension claim for no contributions
Breakdown of claim between May 29, 2013 and November 6, 2013

Dates	Days/Holidays	Daily Hours 7.5	Hourly Rate	% Based on Years of Service	Total
5/30/2013 - 5/31/2013	2	15.00	$42.1252	10.70%	$67.61
6/1/2013 - 6/30-2013	20	150.00	$42.1252	10.70%	$676.11
7/1/2013 - 7/31/2013	23	172.50	$42.1252	10.70%	$777.53
8/1/2013 - 8/31/2013	22	165.00	$42.1252	10.70%	$743.72
9/1/2013 - 9/30/2013	21	157.50	$42.1252	10.70%	$709.91
10/1/2013 - 10/31/2013	23	172.50	$42.1252	10.70%	$777.53
11/1/2013 - 11/5/2013	3	22.50	$42.1252	10.70%	$101.42
				TOTAL	$3,853.82

No claim for sick leave, claimed on prior bankruptcy filing.
No claim for free day, claimed on prior bankruptcy filing.
No claim for vacation days, claimed on on prior bankruptcy filing

Sincere Regards,

Denise M. Wyche
(914) 365-3590
dwyche@sshsw.org

DENISE M. WYCHE
88 GUION PL APT 12W
NEW ROCHELLE, NY 10801

neopost
03/28/2014
US POSTAGE $000.98

FIRST-CLASS MAIL

ZIP 10801
041L12203224

SOUND SHORE MEDICAL CENTER
C/O GCG, INC.
5151 BLAZER PARKWAY, SUITE A,
DUBLIN, OH 43017

13-22840-rdd Doc 1139-14 Filed 06/29/15 Entered 06/29/15 15:01:16
(Part 12) Pg 17 of 24

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).

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Name of Debtor (Check Only One):	Case No.	Name of Debtor (Check Only One):	Case No.
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☐ 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)
Yoga for Business, 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

THE GARDEN CITY GROUP, INC. FEB 14 2014

Name and Addresses Where Notices Should be Sent:
Yoga for Business
P.O.B 138
MT Tremper NY 12457

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): 6/11/2013 7/9/2013 8/6/2013 9/10/2013 10/8/2013

3. DESCRIPTION OF CLAIM (IF KNOWN): Entertainment Exercise Class

FILED - 01463
U.S. BANKRUPTCY COURT FOR THE SOUTHERN DISTRICT OF NEW YORK
SOUND SHORE MEDICAL CENTER OF WESTCHESTER
ROBERT D. DRAIN

4. TOTAL AMOUNT OF ADMINISTRATIVE CLAIM: $ 475 (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.

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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: Brie Van Ham
Title: Pres
Company: Yoga for Business
Address and telephone number (if different from notice address above):

_____ (Signature) _____ (Date)

Telephone number: 917 992 4714 email: bvan@yogaforbusiness.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.

Yoga for Business, Inc.

Tel: 917-992-4714
email: bvanhorn@yogaforbusiness.com
P.O.B. 138 Mt Tremper NY 12457

Invoice

Date	Invoice #
10/14/2013	8470

Bill To	Ship To
Helen Schaffer Ext Care Montefiore Hospital 16 Guion Place New Rochelle, NY 10801 Attn: Activity Dir	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
			10/14/2013			

Quantity	Item Code	Description	Price Each	Amount
1	Therapy	Yomenco 10/8	95.00	95.00T
		Out-of-state sale, exempt from sales tax	0.00%	0.00

Total $95.00

Phone #	Fax #	E-mail
917-992-4714	19175916606	bvanhorn@yogaforbusiness.com

Invoice

Yoga for Business, Inc.

Tel: 917-992-4714
email: bvanhorn@yogaforbusiness.com
P.O.B. 138 Mt Tremper NY 12457

Date	Invoice #
9/15/2013	8420

Bill To	Ship To
Helen Schaffer Ext Care Montefiore Hospital 16 Guion Place New Rochelle, NY 10801 Attn: Activity Dir	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
			9/15/2013			

Quantity	Item Code	Description	Price Each	Amount
1	Therapy	Yomenco 9/10	95.00	95.00T
		Out-of-state sale, exempt from sales tax	0.00%	0.00

Total $95.00

Phone #	Fax #	E-mail
917-992-4714	19175916606	bvanhorn@yogaforbusiness.com

Invoice

Yoga for Business, Inc.

Tel: 917-992-4714
email: bvanhorn@yogaforbusiness.com
P.O.B. 138 Mt Tremper NY 12457

Not Paid

Date	Invoice #
8/14/2013	8357

Bill To	Ship To
Helen Schaffer Ext Care Montefiore Hospital 16 Guion Place New Rochelle, NY 10801 Attn: Activity Dir	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
			8/14/2013			

Quantity	Item Code	Description	Price Each	Amount
1	Therapy	Yomenco 8/6	95.00	95.00T
		Out-of-state sale, exempt from sales tax	0.00%	0.00

Phone #	Fax #	E-mail
917-992-4714	19175916606	bvanhorn@yogaforbusiness.com

Total $95.00

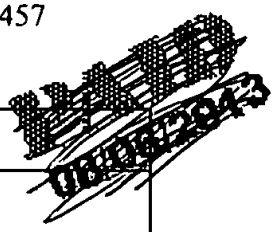
Invoice

Yoga for Business, Inc.

Tel: 917-992-4714
email: bvanhorn@yogaforbusiness.com
P.O.B. 138 Mt Tremper NY 12457

NOT Paid

Date	Invoice #
7/9/2013	8309



Bill To	Ship To
Helen Schaffer Ext Care Montefiore Hospital 16 Guion Place New Rochelle, NY 10801 Attn: Activity Dir	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
			7/9/2013			

Quantity	Item Code	Description	Price Each	Amount
1	Therapy	Yomenco 7/9	95.00	95.00T
		Out-of-state sale, exempt from sales tax	0.00%	0.00

Total $95.00

Phone #	Fax #	E-mail
917-992-4714	19175916606	bvanhorn@yogaforbusiness.com

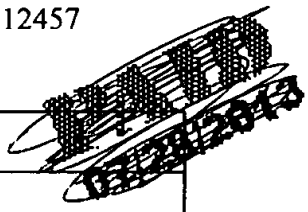
Yoga for Business, Inc.

Tel: 917-992-4714
email: bvanhorn@yogaforbusiness.com
P.O.B. 138 Mt Tremper NY 12457

Invoice

Not Paid

Date	Invoice #
6/14/2013	8261



Bill To	Ship To
Helen Schaffer Ext Care Montefiore Hospital 16 Guion Place New Rochelle, NY 10801 Attn: Activity Dir	

P.O. Number	Terms	Rep	Ship	Via	F.O.B.	Project
			6/14/2013			

Quantity	Item Code	Description	Price Each	Amount
1	Therapy	Yomenco 6/11	95.00	95.00T
		Out-of-state sale, exempt from sales tax	0.00%	0.00

Total $95.00

Phone #	Fax #	E-mail
917-992-4714	19175916606	bvanhorn@yogaforbusiness.com

13-22840-rdd Doc 1139-14 Filed 06/29/15 Entered 06/29/15 15:01:16 Claims
(Part 12) Pg 24 of 24

Equality FOREVER Justice FOREVER Freedom FOREVER

Equator Business
P.O.B. 138
Tremper NY
12457

Sound Shure Medical Et al
C/o GCG Inc
P.O.B. 9982
Dublin Ohio 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 EIGHTH 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 they were untimely filed; the Court having reviewed the Eighth 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 Eighth Objection; and the Eighth 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 Eighth Objection is in the best interest of the Debtors' estate, creditors and other parties in interest; and it appearing that sufficient notice of the Eighth Objection has been given, and the Court having determined that the legal and factual basis set forth in the Eighth Objection establish cause for the relief granted herein; and after due

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

deliberation and consideration of the Motion having been had; and it appearing that good and sufficient cause exists for granting the Eighth Objection, it is hereby

ORDERED, that the relief requested in the Eighth 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 EIGHTH 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 EIGHTH OMNIBUS OBJECTION TO CLAIMS THAT ARE FILED LATE

PLEASE TAKE NOTICE, that a hearing on the annexed Eighth Omnibus Objection to Claims, dated June 30, 2015 (the "Eighth 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 Eighth Omnibus Objection.

ALL PARTIES RECEIVING THIS NOTICE SHOULD REVIEW THE EIGHTH 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 Eighth 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 Eighth 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 Eighth 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 Eighth 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