**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.

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: _____

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):
_____
_____
_____
Telephone number: _____

_____
(Signature) (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.