

UNITED STATES BANKRUPTCY COURT DISTRICT OF DELAWARE	ADMINISTRATIVE EXPENSE PROOF OF CLAIM	Administrative Expense Claims Bar Date
Sherman/Grayson Hospital, LLC (Case No. 23-10810(JKS))		
Name of Creditor (The person or entity to whom the debtor owes money or property)	<input type="checkbox"/> 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: <input type="checkbox"/> replaces or <input type="checkbox"/> amends a previously filed administrative expense claim. Claim Number (if known): _____ Dated: _____
Name and Addresses Where Notices Should be Sent: Contact phone: _____ Contact email: _____	Name and Addresses Where Payment Should be Sent (if different): Contact phone: _____ Contact email: _____	
1. BASIS FOR CLAIM:		
2. DATE DEBT WAS INCURRED (IF KNOWN):		
3. DESCRIPTION OF CLAIM (IF KNOWN):		
4. TOTAL AMOUNT OF 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 of claim. 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
Date:	Sign and print the name and title, if any, of the creditor or other person authorized to file this Claim (attach copy of power of attorney, if any)	