**RECEIVERSHIP PROOF OF CLAIM FORM**

I, _____, being duly sworn, depose and say:

_____ (INDIVIDUAL) I am the claimant herein.

_____ (PARTNERSHIP) I am a partner of _____ which is the claimant herein.

_____ (CORPORATION) I am an officer, to wit, _____, of _____which is the claimant herein.

The full address of the claimant is _____ (complete address, including zip code) _____.

That on the _____ day of _____, 2023, **Pawtucket SNF Operator, LLC d/b/a Pawtucket Falls Health Care Center, located at 70 Gill Avenue, Pawtucket, Rhode Island 02861**, did owe and still does owe the claimant a balance of $_____ dollars, a statement of which account is attached hereto.

That such account is just, true and correct, and said balance is now due claimant from debtor.

That no part thereof has been paid or satisfied, and that there are no set-offs, or counterclaims thereto, to the knowledge or belief of deponent and that no security exists for said debt.

That the attorneys named on this Proof of Claim are hereby made and constituted attorneys for all purposes whatsoever in connection with this claim with full power of substitution (if an attorney is filing for you).

_____
(Signature of Claimant)

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me on this _____ day of _____, _____.

_____
Notary Public
My Commission Expires:_____