AGREEMENT FOR THE ASSIGNMENT AND ASSUMPTION
of
RESIDENT TRUST FUNDS

This **AGREEMENT FOR THE ASSIGNMENT AND ASSUMPTION OF RESIDENT TRUST FUNDS** (the "Agreement") is entered into as of June 30, 2017, to be effective as of 12:01 a.m., HST, on July 1, 2017 ("Effective Time"), by and between MAUI REGION OF HAWAII HEALTH SYSTEMS CORPORATION, an agency of the State of Hawaii established in Section 323F-2(b)(3) and 323F-3.5 of the Hawaii Revised Statutes ("Assignor"), and MAUI HEALTH SYSTEM, A KAISER FOUNDATION HOSPITALS LLC, a Hawaii limited liability company ("Assignee").

BACKGROUND

A. Assignor and Assignee are parties to that certain Maui Regional Hospitals Transfer Agreement dated as of January 14, 2016 (the "Transfer Agreement"), as may be amended. Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to them in the Transfer Agreement.

B. It is a condition to the Closing under the Transfer Agreement that Assignor assign to Assignee all of Assignor's right, title, and interest in and to the Resident Trust Funds held by Assignor for the benefit of certain Residents receiving Skilled Nursing Services as of the Effective Time at the SNF within: (i) Lanai Community Hospital located at 628 7th Street, Lanai City, Hawaii 96763 ("LCH"); or (ii) Kula Hospital & Clinic located at 100 Keokea Place, Kula, Hawaii 96790 ("Kula"), and that Assignee assume Assignor's obligations with respect to such Resident Trust Funds, subject to the terms, conditions and limitations set forth herein and in the Transfer Agreement.

C. Assignor and Assignee have determined that it is the best interests of the Residents of LCH and Kula that Assignor assign and transfer to Assignee, and that Assignee assumes Assignor's current bank accounts that hold the Resident Trust Funds for LCH and Kula (the "Resident Trust Fund Accounts").

NOW, THEREFORE, in consideration of the premises, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

1. Assignor hereby assigns, transfers, and conveys all of its right, title and interest in and to the Resident Trust Funds to Assignee as of the Effective Time, such Resident Trust Funds being further described on **Exhibit A**, attached hereto and incorporated herein by reference, in connection with Assignees assumption of the Resident Trust Funds and the Resident Trust Fund Accounts.

2. Subject to the limitations set forth below, Assignee hereby assumes all liabilities arising as of, or after, the Effective Time with respect to the Resident Trust Funds and the Resident Trust Fund Accounts, and agrees to assume custody of such Resident Trust Funds in

trust for the applicable Residents and to be accountable to such Residents for such Resident Trust Funds and to assume the custodial obligations arising as of, or after, the Effective Time with respect to the Resident Trust Funds and the Resident Trust Fund Accounts, in accordance with applicable statutory and regulatory requirements.

3. Attached hereto as **Exhibit A** is a true, correct, and complete accounting of all Resident Trust Funds as of the Effective Time.

4. Assignee shall have no responsibility to any Resident, responsible party or Governmental Entity in the event the Resident Trust Funds delivered by Assignor are subsequently demonstrated to be less than the full amount of the Resident Trust Funds for any Resident as of the Effective Time, for any inaccuracies in the accounting provided by Assignor, or for claims which arise from any actions or omissions of Assignor with respect to, or any other liability with respect to, any Resident Trust Funds prior to the Effective Time, all of which shall remain the sole responsibility of Assignor. Subject to the terms and conditions hereof, nothing contained in this Agreement shall be construed as imposing any liability on Assignor for the acts or omissions of Assignee, or any other liability arising with respect to the Resident Trust Funds actually transferred to Assignee via Assignee's assumption of the and the Resident Trust Fund Accounts, in each case subsequent to the Effective Time, all of which shall be the sole responsibility of Assignee.

5. This Agreement may be signed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. The exchange of copies of this Agreement and of signature pages by facsimile transmission or Portable Document Format (PDF) constitutes effective signing and delivery of this Agreement as to the Assignor and Assignee, as applicable, and may be used in lieu of the original Agreement for all purposes. Signatures of the Assignor and Assignee transmitted by facsimile and PDF are deemed to be their original signatures for any purposes whatsoever.

[Remainder of this page intentionally left blank;
Signatures appear on next page.]

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Assignment and Assumption Agreement of Resident Trust Funds as of the day and year first above written.

ASSIGNOR:

MAUI REGION OF HAWAII HEALTH SYSTEMS CORPORATION,
an agency of the State of Hawaii

By: _____
Name: Barry Shitamoto, M.D.
Title: Regional Chief Executive Officer

ASSIGNEE:

MAUI HEALTH SYSTEM, A KAISER FOUNDATION HOSPITALS LLC,
a Hawaii limited liability company

By: _____
Name: Mary Ann Barnes
Title: Chairperson of the Board

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Assignment and Assumption Agreement of Resident Trust Funds as of the day and year first above written.

ASSIGNOR:

MAUI REGION OF HAWAII HEALTH SYSTEMS CORPORATION,
an agency of the State of Hawaii

By: _____
Name: Barry Shitamoto, M.D.
Title: Regional Chief Executive Officer

ASSIGNEE:

MAUI HEALTH SYSTEM, A KAISER FOUNDATION HOSPITALS LLC,
a Hawaii limited liability company

By: Mary Ann Barnes
Name: Mary Ann Barnes
Title: Chairperson of the Board

Exhibit A
Resident Trust Fund Accounting

[See attached.]

EXHIBIT A

KULA RESIDENT TRUST FUNDS

1. American Savings Bank Trust Account Signature Cards, with associated information.

2. Kula Hospital Resident Balances – reconciliation as of 5/31/2017.

3. Kula Hospital Resident Trust Account Letter (American Savings Bank form letter).

LANAI RESIDENT TRUST FUNDS

1. First Hawaiian Bank Trust Account Signature Cards, with associated information.

2. Lanai Community Hospital Individual Resident (x2) Trust Account Balances – reconciliation as of 5/31/2017.

Ex. A, Kula Resident Trust Funds #1

SIGNATURE CARD

AMERICAN Savings Bank

P.O. Box 2300 Honolulu, HI 96804-2300

ACCOUNT INFORMATION

Product Name: **Biz Statement Savings**

Account Number: **3003852497**

Date Opened: **08/03/2009**

Opened By: **Ryan Sherwood**

Name and address:

Kula Hospital
100 Keokea Pl
Kula, HI Usa 96790

Tax ID number: **99-0262276**

Contact Information:

Contact name:

Contact title:

Business phone:

Established date:

Owner(s) or Authorized Signer(s)

Owner/Signer #1 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #2 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #3 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #4 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Beneficiary Designation. The following beneficiary(ies) are designated

1. 2.

3. 4.

Designation of Successor Custodian for HUTMA

I Paul HARPER-O'Connor as custodian for Kula Hospital under the Hawaii Uniform

Transfer to Minors Act I designate the following as successor custodian: Paul Harper-O'connor

Custodian: X Paul Harper-O'connor

Witness by: X N Garrity

Name of witness:

To American Savings Bank ("ASB"): ASB is authorized to recognize any one of the signatures subscribed below in the payment and/or withdrawal of funds, or the transaction of any business or receipt of any information for this account. It's agreed that all transactions between ASB and the undersigned shall be governed by the Personal Deposit Account Rules or the Business Deposit Account Rules (as applicable) and the Personal Deposit Account Disclosures and Fees or the Business Deposit Account Disclosures and Fees (as applicable), by signing below, receipt of the foregoing is confirmed. Also by signing below, the undersigned authorize(s) the procurement of a credit report (consumer or credit report) by ASB.

☒ Checking this box indicates that the undersigned represent(s) that this is a business account and is therefore not for personal, household, or family use. If there is a change in authorized signers, the undersigned agrees to provide a signed certification from the retiring signer reflecting the same.

X N Garrity	Signer #1 name and title:	**Nerissa Garrity, Aut**
X Jane Dellaport	Signer #2 name and title:	**Jane Dellaport, Aut**
X Ernette Kaea-Prones	Signer #3 name and title:	**Ernette Kaea-Prones, Aut**
X Joyce Tamori	Signer #4 name and title:	**Joyce Tamori, Aut**

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION		
Under penalties of perjury, I certify that 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined in the instructions) 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Exemption from FATCA reporting code (if any) NOT APPLICABLE **Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.		
Sign Here	Signature of U.S. person N Garrity	Date ▶ **06/22/2017**

SIGNATURE CARD

P.O. Box 2300 Honolulu, HI 96804-2300

ACCOUNT INFORMATION

Product Name: **Biz Simple Checking**

Account Number: **8003204406**

Date Opened: **08/03/2009**

Opened By: **Ryan Sherwood**

Tax ID number: **99-0262276**

Name and address:

Kula Hospital
100 Keokea Pl
Kula, Hi Usa 96790

Contact Information:

Contact name:

Contact title:

Business phone:

Established date:

Owner(s) or Authorized Signer(s)

Owner/Signer #1 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #2 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #3 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #4 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Beneficiary Designation. The following beneficiary(ies) are designated:

1. 2.

3. 4.

Designation of Successor Custodian for HUTMA

I Paul Harper-O'Connor as custodian for Kula Hospital under the Hawaii Uniform Transfer to Minors Act I designate the following as successor custodian: Paul Harper-O'connor

Custodian: X Paul H O'C Witness by: X A Garrity

Name of witness:

To American Savings Bank ("ASB"): ASB is authorized to recognize any one of the signatures subscribed below in the payment and/or withdrawal of funds, or the transaction of any business or receipt of any information for this account. It's agreed that all transactions between ASB and the undersigned shall be governed by the Personal Deposit Account Rules or the Business Deposit Account Rules (as applicable) and the Personal Deposit Account Disclosures and Fees or the Business Deposit Account Disclosures and Fees (as applicable); by signing below, receipt of the foregoing is confirmed. Also by signing below, the undersigned authorize(s) the procurement of a credit report (consumer or credit report) by ASB.

☒ Checking this box indicates that the undersigned represent(s) that this is a business account and is therefore not for personal, household, or family use. If there is a change in authorized signers, the undersigned agrees to provide a signed certification from the retiring signer reflecting the same.

X A Garrity	Signer #1 name and title:	**Nerissa Garrity, Aut**
X Jane T. Dellaport	Signer #2 name and title:	**Jane Dellaport, Aut**
X Ernette Kaea Prones	Signer #3 name and title:	**Ernette Kaea-Prones, Aut**
X Joyce Tamori	Signer #4 name and title:	**Joyce Tamori, Aut**

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION		
Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person (defined in the instructions) 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. Exemption from FATCA reporting code (if any) NOT APPLICABLE. **Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.		
Sign Here	Signature of U.S. person A Garrity	Date ▶ **06/22/2017**

SIGNATURE CARD

AMERICAN Savings Bank

P.O. Box 2300 Honolulu, HI 96804-2300

ACCOUNT INFORMATION

Product Name: **Kalo Simple Checking**

Account Number: **8102676302**

Date Opened: **07/07/2016**

Opened By: **Ryan Sherwood**

Name and address:

Trustee (Secondary)
Kula Hospital
100 Keokea Pl
Kula, Hi Usa 96790

Tax ID number:

Contact Information:

Contact name:

Contact title:

Business phone:

Established date:

Owner(s) or Authorized Signer(s)

Owner/Signer #1 name, title and address:

Isamu Kajita
100 Keokea Pl
Kula, Hi Usa 96790

Tax ID number: **576-30-1639**

Date of birth: **04/22/1931**

Primary ID type: **U.S. Drivers License**

Primary ID number: **H00176790**

Primary ID issue entity: **State/County Government**

Primary ID issue location: **Hawaii**

Primary ID issue date: **03/31/2011**

Primary ID expiration date: **04/22/2012**

Owner/Signer #2 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #3 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Owner/Signer #4 name, title and address:

Tax ID number:

Date of birth:

Primary ID type:

Primary ID number:

Primary ID issue entity:

Primary ID issue location:

Primary ID issue date:

Primary ID expiration date:

Beneficiary Designation. The following beneficiary(ies) are designated:

1. 2.

3. 4.

Designation of Successor Custodian for HUTMA

I Paul Harper-A'Gunnell as custodian Kula Hospital Administrator under the Hawaii Uniform Transfer to Minors Act I designate the following as successor custodian: _____

Custodian: X _____ Witness by X _____

Name of witness: _____

To American Savings Bank ("ASB"): ASB is authorized to recognize any one of the signatures subscribed below in the payment and/or withdrawal of funds, or the transaction of any business or receipt of any information for this account. It's agreed that all transactions between ASB and the undersigned shall be governed by the Personal Deposit Account Rules or the Business Deposit Account Rules (as applicable) and the Personal Deposit Account Disclosures and Fees or the Business Deposit Account Disclosures and Fees (as applicable); by signing below, receipt of the foregoing is confirmed. Also by signing below, the undersigned authorize(s) the procurement of a credit report (consumer or credit report) by ASB

☐ Checking this box indicates that the undersigned represent(s) that this is a business account and is therefore not for personal, household, or family use. If there is a change in authorized signers, the undersigned agrees to provide a signed certification from the retiring signer reflecting the same.

X _____	Signer #1 name and title:	**Nerissa Garrity, Aut**
X _____	Signer #2 name and title:	**Jane Dellaport, Aut**
X _____	Signer #3 name and title:	**Ernette Kaea-Prones, Aut**
X _____	Signer #4 name and title:	**Joyce Tamori, Aut**

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined in the instructions)
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Exemption from FATCA reporting code (if any) NOT APPLICABLE

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Sign Here	Signature of U.S. person _____	Date ▶ 06/13/2017

Ex A, Kula Resident Trust Funds, # 2

TRUST ASB FY17

1	2	3	4	5	6	23
					TF	RECON BAL
	KULA	ACCT#	PAYEE	PATIENT NAME	PC	5/31/2017
KH ID #	OPEN ACCT		ID #			
						-
100	12/15/2014	30038-52497	ONLINE	ALBIAR, GUILHERMINA R	TF	1,335.86
101	8/1/2014	30038-52497	ONLINE	AMORIN, WINONA	TF	1,241.70
102	5/8/2014	30038-52497	ONLINE	ANTONIO, HANNAH	TF	1,683.16
103	7/18/116	30038-52497	ONLINE	APOLIONA, JUDITH	TF	1,719.01
104	1/22/2014	30038-52497	ONLINE	BAUGH, MARY LOU	TF	1,654.11
105	1/1/2016	30038-52498	ONLINE	BAYBAYAN, CARLINA D	TF	31.63
106	4/14/2015	30038-52497	ONLINE	BESCH, MICHAEL	TF	1,141.31
107	4/6/2014	30038-52497	ONLINE	DANG, MYRA	TF	130.26
108		30038-52497	ONLINE	DECAMBRA, JOSEPHINE	TF	1,604.58
109	12/18/2015	30038-52497	ONLINE	ELKIN, EDWIN	TF	1,512.97
110	8/3/2015	30038-52497	ONLINE	ENGLISH, GORDON B	TF	49.01
111	5/9/2017	30038-52497	ONLINE	ESTRELLA, MARY	TF	1,137.02
112	3/3/2015	30038-52497	ONLINE	GIBSON, LESLEY	TF	585.41
113	12/3/2014	30038-52497	ONLINE	GUSMAN, CARMEN	TF	880.01
114		30038-52497	ONLINE	HENSLEY, KRISTA JOY	TF	1,626.72
115		30038-52497	ONLINE	HENSLEY, SARAH JILL	TF	1,569.41
116		30038-52497	ONLINE	HEYER, ROBERT	TF	297.13
117		30038-52497	ONLINE	HIGA, SACHIKO**	TF	1,353.47
118		30038-52497	ONLINE	IDETA, ELLEN	TF	1,430.23
119	4/3/2015	30038-52497	ONLINE	ITO, ANN	TF	284.86
120	9/13/2016	30038-52497	ONLINE	ITO, JAMES	TF	651.60
121		30038-52497	ONLINE	KAHOOHANOHANO, KELLY	TF	1,732.68
122	5/13/2014	30038-52497	ONLINE	KAONA, RITA	TF	538.88
123		30038-52497	ONLINE	KEGLEY, LUCY	TF	1,922.43
124		30038-52497	ONLINE	KIM, BRENT	TF	172.08
125		30038-52497	ONLINE	KRATZMAN, STEPHANIE	TF	503.11
126		30038-52497	ONLINE	KUBO, MIEKO	TF	1,247.03
127	10/19/2015	30038-52497	ONLINE	KURISU, JANE T	TF	1,589.47
128	11/20/2013	30038-52497	ONLINE	LIND, DAISY M	TF	992.83
129		30038-52497	ONLINE	LUCENA, BRITNEY	TF	1,651.76
130		30038-52497	ONLINE	MAKEKAU, JULIE	TF	18.56
131	5/9/2014	30038-52497	ONLINE	MALCOLM, GEORGIANA	TF	50.24
132	1/14/2015	30038-52497	ONLINE	MARTIN, PAUL H	TF	995.67
133	9/2/2016	30038-52497	ONLINE	MAU, PEGGY	TF	137.44
134		30038-52497	ONLINE	MYLENEK, MARGARET	TF	502.33
135	9/9/2016	30038-52497	ONLINE	NAKOA, ALICE	TF	1,742.13
136	1/21/2015	30038-52498	ONLINE	NIKAIDO, ELTON	TF	55.84
137	6/3/2014	30038-52497	ONLINE	O'CONNOR, MARGARET	TF	1,427.99
138	12/3/2015	30038-52497	ONLINE	PRENDERGAST, NANCY	TF	1,799.42
139	11/3/2014	30038-52497	ONLINE	PUNIO, TERESA	TF	99.46
140	8/5/2014	30038-52497	ONLINE	REDDY, RONALD	TF	55.17
141	8/18/2016	30038-52497	ONLINE	ROBERTS, REGINA	TF	58.68
142		30038-52497	ONLINE	SANDERS, JENNIFER	TF	4,662.97
143	7/28/2016	30038-52497	ONLINE	SOUZA, THOMAS	TF	185.82
144	10/21/2009	30038-52497	ONLINE	STILES, ADELINE	TF	1,827.10
145	12/13/2016	30038-52497	ONLINE	SWINNERTON, THOMAS	TF	92.10
146		30038-52497	ONLINE	TAMAYOSE, ROSS	TF	956.18

147		30038-52497	ONLINE	TORRES JR, MICHAEL	TF	434.20
148		30038-52497	ONLINE	VARES, JOANNE	TF	197.91
149		30038-52497	ONLINE	VILLANUEVA, PRIMITIVA	TF	850.85
150		30038-52497	ONLINE	VINCENT, SARAH	TF	-
151	11/3/2014	30038-52497	ONLINE	WALTON, WILLIAM	TF	-
152	1/3/2014	30038-52497	ONLINE	WHITE, ROSE	TF	1,824.80
153		30038-52497	ONLINE	KULA HOSPITAL/ SVC FEE		5.97
						50,250.56

		RECON BAL
	Account:	5/31/2017
PATIENT NAME		
KAJITA, ISAMU	81026-76302	1298.30
TOTAL		1298.30

Ex. A, Kula Resident Trust Fund, # 3

Kula Hospital
ATTENTION: ADMINISTRATOR
100 Keokea Place
Kula, HI 96790

Re: Authorization Regarding American Savings Bank Account

Dear Sir or Madame:

I, _____, understand that I have the right to manage my financial affairs and am not required to deposit my personal funds with Kula Hospital ("Hospital").

I, _____, hereby request and authorize the Hospital to assist me by managing my personal funds. I authorize the Hospital's Administrator (including someone designated by the Administrator) to endorse checks payable to me and deposit them into a pooled interest-bearing account for residents' personal funds, held in the name of Hospital, at American Savings Bank, for so long as I remain a Hospital resident. I further authorize the Administrator to make withdrawals on my behalf, to participate in online banking, to execute any necessary documents and incur any necessary fees in connection with the above functions and to share this authorization with American Savings Bank.

I understand that withdrawals on my behalf will be made for payment or reimbursement of expenses incurred for my health, benefit or welfare, including but not limited to charges for my care at the Hospital and "resident request" items and services. I understand that I will receive a statement of my individual financial record on a quarterly basis and upon request. If I should die while a Hospital resident, I understand that any of my remaining personal funds from this account and a final accounting will be conveyed to the individual or probate jurisdiction administering my estate.

I hereby release you and American Savings Bank from liability of any kind (except gross negligence) in connection with the deposits and withdrawals made on my behalf.

_____ _____
Signature of Resident or Resident's legal representative Date

---

State of Hawaii)
:SS
County of Maui)

On this _____day of _____, 20____, before me personally appeared _____, to me known to be the person who executed the foregoing instrument in behalf of _____, (as his/her Attorney-in-Fact), and acknowledged that (s)he executed the same as the free act and deed of said _____.

NOTARY PUBLIC CERTIFICATION

Doc. Date: _____ # Pages: _____
Notary Name: _____ Judicial Circuit:_____
Doc. Description: _____
Notary Signature: _____
Date:

_____
Notary Public, State of Hawaii
Printed Name: _____
My commission expires: _____

Ex. A, Lanai Resident Trust Funds, #1

ALL ACCOUNTS LISTED BELOW MUST BE HELD IN THE SAME OWNERSHIP

Account Type	Account Number	Date Opened	Customer Init.	Open/ Rev By	Date Closed
Checking	24-019071	08/26/08	PH		

CM-507 (REV. 7/1/01) (FRONT) SGCORP **

MaxiMizer Telephone Transfers: ___ Accept telephone requests from any one of the authorized signer(s) to transfer funds between the following accounts: ___MMA ___Checking and ___ Cust. Init.

Telephone Transfer Revocation: I hereby revoke my request to transfer funds by telephone between the accounts listed in this section: Date:

Mailing Address: P O Box 630650
Lanai City, HI 96763

Phone 808-565-8450 Fax Phone 808-565-8474

Type of Business Residential Patient Care

X Superseding Card Superseding Date 05/03/10 Initials ____ No. of Cards: 1 of 1

First Hawaiian Bank — **Corporation Account Signature Card**

Name of Corporation: Lanai Community Hospital Resident Trust Fund

Federal ID Number: 99-0262191

Under penalties of perjury, I certify: (1) that the number shown above is my correct taxpayer identification number and (2) that I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person (or a U.S. resident alien). *(Cross out item (2) above if the IRS notified you that you are subject to backup withholding.)*

Signature of U.S. Person: Paul H

Date: 05/03/2010 ___ Exempt

The above-named corporation, acting by those signatories on the reverse side of this card, hereby agrees that this account shall be subject to First Hawaiian Bank's ("Bank") rules, regulations, practices, and applicable laws for the account(s), which may change from time to time. The corporation acknowledges that it has received a copy of the Bank's Deposit Account Rules and Regulations and Other Information, as well as initial account disclosures containing account charges and other information applicable to my account(s). The corporation understands that the Bank will rely on information provided on this card.

	Authorized Signature Specimen	Title
1	Paul H	Act ADMSTR
2	Margaret Daub	Dir of Nurse
3	Arlene Locquiao	Acct Clerk
4		

Name	Name
1 Paul Harper	3 Arlene Locquiao
2 Maggie Daub (Margaret Daub)	4

Please sign within signature block with BLACK INK.

Paul H	Signature (1)
Paul Harper	Name Typed
Margaret Daub	Signature (2)
Maggie Daub (Margaret Daub)	Name Typed
Arlene Locquiao	Signature (3)
Arlene Locquiao	Name Typed
	Signature (4)
	Name Typed

FOR BANK USE ONLY

No. of Cards: 1 of 1 | Account No.: 24-019071

Account Name: Lanai Community Hospital Resident Trust Fund

No. of Sig. Req'd.: 1

Card Status: ___ New Acct. ___ Reopened Acct. X Superseding ___ Temporary Card

Effective Date: 05/03/2010

Enter Special Instructions on Reverse Side of Card

CM-507 (REV. 7/1/01) (FRONT) SGCORP **

SPECIMEN SIGNATURE CARD

Location Address: 628 Seventh Street
Lanai City, HI 96763

Account Comments:

Warnings:

Specimen Signature Card Special Instructions:

Documentation Required to Open Account	Received
Articles of Incorporation	On File
Federal ID Number	On File
Additional Documentation Board Of Director Minutes	
Corporate Resolution	
Corporate Seal (optional)	
Annual Exhibit	

Effective Date of Card 05/03/2010 Date Orig. Op. 08/26/2008 No. Sig. Req. 1
Uni-Ck Exis Opened By Sally Reviewed By _____ Contact Officer E Magaoay

CORPORATE RESOLUTION OF AUTHORITY

"RESOLVED, that any (specify no.) 1 of the following (specify titles of individuals required to sign checks, etc.) _____

of this Corporation is (are) authorized, on behalf of this Corporation and in its name, to sign bank checks and drafts for the withdrawal of funds, drawn on First Hawaiian Bank (the "Bank") as a depository of this Corporation; to sign, or otherwise make, requests and receipts for the withdrawal of funds; to indorse and accept checks, drafts, notes, and other paper payable to or by this Corporation; to waive protest of any check, note, bill, or other item made, drawn, or indorsed by or to the order of this Corporation; and to enter into agreements with the Bank relative to the account or accounts of this Corporation in the Bank.

"FURTHER RESOLVED, that the Bank be and it hereby is authorized to honor, receive, certify, or pay all instruments and requests signed or made in accordance with the foregoing Resolution even though drawn or indorsed to the order of the person signing the same, or tendered in payment of his individual obligation, or for deposit to his personal account, or tendered for cashing, and the Bank shall have no obligation to inquire as to the circumstances of issuance, use or disposition of such instrument or application of the proceeds thereof.

"FURTHER RESOLVED, that the Bank may, without prior notice to or the consent of the Corporation or any of its officers, directors, or shareholders, set off against the account(s) and deduct therefrom, the amount of any expenses and attorneys' fees incurred in connection with any dispute or litigation involving this account(s) in which the Bank is not at fault.

"FURTHER RESOLVED, that the Secretary or Assistant Secretary shall certify to the Bank the names of the persons presently holding the office or position above stated, and from time to time shall immediately certify to the Bank any changes in the same, and the Bank shall be fully protected in relying on such certification.

"FURTHER RESOLVED, that the foregoing Resolutions shall remain in full force and effect until written notice of their amendment or revocation shall have been received by the Bank and until the Bank has had a reasonable time to act thereon after its receipt.

"FURTHER RESOLVED, that the Secretary or Assistant Secretary be and he hereby is authorized and directed to deliver a certified copy of the foregoing Resolutions to the Bank.

"FURTHER RESOLVED, that the Bank shall be fully protected in relying on these resolutions, and shall be indemnified and saved harmless from any claims, demands, expenses, loss, or damage resulting from any such reliance."

I hereby certify that the foregoing is a full, true, and correct copy of the Resolutions duly adopted by the Board of Directors of (Name of Corporation) _____ (the Corporation), at a meeting duly and regularly called and held on 04/26/2010, or by such resolution unanimously adopted by written consent of the Board of Directors dated 04/26/10; that such resolutions are duly recorded and appear in the minute book of the Corporation and have not been altered, amended, nor revoked; and that the foregoing specimen signatures appearing on the reverse hereof are those of the persons holding the offices or positions there indicated.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed the seal of said Corporation this 26th day of August 2008.

CM-507 (REV. 7/1/01) (BACK) SGCORP **

Secretary or Assistant Secretary

FOR BANK USE ONLY

Special Instructions: (Maximum 149 Positions)
Type instructions below; abbreviate where possible.

CM-507 (REV. 7/1/01) (BACK) SGCORP **

Ex. A, Lanai Resident Trust Funds, #2

LANAI COMMUNITY HOSPITAL

HAWAII HEALTH SYSTEMS
CORPORATION
STATE OF HAWAII

"Touching Lives Everyday"

TRUST FUND ACCOUNT AGREEMENT

Patient Name: Reuben Eskaran Sr.
MR#: 61087992

So long as I (patient/resident's name), Reuben Eskaran Sr., ("patient/resident") remain a patient/resident at LANAI COMMUNITY HOSPITAL ("Hospital"), I hereby authorize the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident.

In order to facilitate this process, I further authorize the Hospital to open any first class mail addressed to me from:

_____

for the purpose of removing checks to be deposited into my/the patient/resident's account and to pay medical bills.
I understand that a summary of transactions involving my account is distributed quarterly or at any time on request.

Upon death and after payment of any outstanding medical bills, funds are to be disbursed to my/the patient/resident's:

( ) personal representative
(✓) power of attorney
(✓) designated beneficiary
( ) legal guardian

Payee's name: Barbara A. Eskaran
Payee's address: PO Box 630607
Lanai City, HI 96763
Telephone #: (808) 565 - 6117 (H) 808-563-1351 (c)

I know of no reason which prevents me/the patient/resident from entering into this agreement which purpose is to
permit the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident.

Signature: Barbara A. Eskaran Date: 08/18/15
Relationship to Patient: Spouse
Witnessed by: Helena McClure Date: 8/18/2015
Witnessed by: Randolph Moore Date: 8/18/2015

Subscribed and Sworn to before me this
18th Day of August In the year 2015

Jerrilyn Yumoi
Notary Public State of Hawaii, 2nd Judicial Circuit
My commission expires: 2/19/2016

NOTARY PUBLIC CERTIFICATION
Jerrilyn Yumoi Second Judicial Circuit
Doc Description: Lanai Community Hospital Trust Fund Account Agreement
No of Pages: 1 Date of Doc. Undated

Jerrilyn Yumoi 8/18/2015
Notary Signature Date

Lanai Community Hospital
628 Seventh Street
Lanai City, HI 96763

Patient Trust Fund Statement

Reuben Eskaran
PO Box 630650

Lanai City, HI 96763

Patient Name: Reuben Eskaran

For Period May 01, 2017 to Ending May 31, 2017

Account Summary:

Beginning Balance		[redacted]
		156.90
PLUS:		
Deposits	1,754.00	
Interest Earned	.00	1,754.00
		1,910.90
Less:		
Cost Share	1,699.00	
Other	100.00	1,799.00
Ending Balance		[redacted]

NOTICE: In order for you to remain eligible for SSI and/or other medical assistance, your personal funds may not exceed $2,000. You now have [redacted] in you personal funds.
If you have any questions about your statement, please call Business Office at 733-7927.

LANAI COMMUNITY HOSPITAL

HAWAII HEALTH SYSTEMS
CORPORATION
STATE OF HAWAII

"Touching Lives Everyday"

TRUST FUND ACCOUNT AGREEMENT

Patient Name: Walter E. Lischka
MR #: 47393

So long as I (patient/resident's name), Walter E. Lischka, ("patient/resident") remain a patient/resident at LANAI COMMUNITY HOSPITAL ("Hospital"), I hereby authorize the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident.

In order to facilitate this process, I further authorize the Hospital to open any first class mail addressed to me from:

_____

for the purpose of removing checks to be deposited into my/the patient/resident's account and to pay medical bills. I understand that a summary of transactions involving my account is distributed quarterly or at any time on request.

Upon death and after payment of any outstanding medical bills, funds are to be disbursed to my/the patient/resident's:

( ) personal representative
( ) power of attorney
( ) designated beneficiary
( ) legal guardian

Payee's name: _____
Payee's address: _____
_____
Telephone #: _____

I know of no reason which prevents me/the patient/resident from entering into this agreement which purpose is to permit the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident.

Signature: Walter Lischka Date: 02/19/2013
Relationship to Patient: Self

Witnessed by: Elsie Bontay Date: 2/19/13
Witnessed by: Lorina Amby Date: 2/19/13

Subscribed and Sworn to before me this
_____ Day of _____ in the year _____

_____
Notary Public State of Hawaii, _____ Judicial Circuit
My commission expires: _____

Lanai Community Hospital
628 Seventh Street
Lanai City, HI 96763

Patient Trust Fund Statement

Walter Lischka
PO Box 630650

Lanai City, HI 96763

Patient Name: Walter Lischka

For Period May 01, 2017 to Ending May 31, 2017

Account Summary:

Beginning Balance		[redacted] 1,179.06
PLUS:		
Deposits	2,475.07	
Interest Earned	.00	2,475.07
		3,654.13
Less:		
Cost Share	2,168.00	
Other	10.00	2,178.00
Ending Balance		[redacted] 1,476.13

NOTICE: In order for you to remain eligible for SSI and/or other medical assistance, your personal funds may not exceed $2,000. You now have [redacted] $1,476.13 in you personal funds.
If you have any questions about your statement, please call Business Office at 733-7927.