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 "<u>Transfer Agreement</u>"), 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 ("<u>LCH</u>"); or (ii) Kula Hospital & Clinic located at 100 Keokea Place, Kula, Hawaii 96790 ("<u>Kula</u>"), 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 "<u>Resident Trust Fund Accounts</u>").

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: 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 (imited liability company

trang linn Bance By:

Name: Mary Ann Barnes Title: Chairperson of the Board

[Signature Page to Agreement for the Assignment and Assumption of Resident Trust Funds]

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

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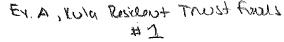
- 1. First Hawaiian Bank Trust Account Signature Cards, with associated information.
- 2. Lanai Community Hospital Individual Resident (x2) Trust Account Balances reconciliation as of 5/31/2017.

AGREEMENT FOR THE ASSIGNMENT AND ASSUMPTION OF RESIDENT TRUST FUNDS

SIGNATURE CARD

ACCOUNT INFORMATION

Product Name: **Biz Statement Savings**





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

Account Number: 3003852497 Date Opened: 08/03/2009

Opened By: Ryan Sherwood

Name and address:

Kula Hospital 100 Keokea PI Kula, Hi Usa 96790

Owner(s) or Authorized Signer(s) Owner/Signer #1 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #2 name, title and address:

Primary ID Issue entity: Primary ID issue date:

Owner/Signer #3 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #4 name, title and address:

Primary ID issue entity: Primary ID issue date:

Tax (D number: 99-0262276 Contact Information: Contact name: Contact title: Business phone: Established date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number; Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

American Savings Bank New Account Information

3003852497

Beneficiary	/ Designation.	The following beneficiary(ies) are designated
=qupueidi ;	a nan Gina a an	The renorming canonicary(nuc) and canonican

1.	2.
3.	4.
Designation of Successor Custodian for HUTMA	for Kula Haspitz under the Hawaii Uniform
Transfer to Minors Act I designate the following as successor Custodian: X Paul 497	Deul Harros Classics
0	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 memory of a study correctly construct or study forend by ACP. 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.

× Maarviitaz	Signer #1 name and tille:	Nerissa Garrity, Aut
× Jone 7 Allaport	Signer #2 name and title:	Jane Dellaport, Aut
× Consty Jay Juns	Signer #3 name and lille:	Ernette Kaea-Prones, Aut
× John Jamon	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 failu	re to report all interest or dividends, or (c) the							
IRS has notified me that I am no longer subject to backup withholding, and								
I am a U.S. citizen or other U.S. person (defined in the instructions)								
The FATCA code(s) entered on this form (if any) indicating that I am exempt from FAT	CA 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	te IRS that you are currently subject to backup							
withholding because you have failed to report all interest and dividends on your tax return.								
Sign Signature of CAL ALL	06/22/2017							
Here U.S. person U.G. avitz	Date ►							

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SIGNATURE CARD

ACCOUNT INFORMATION

Product Name: Biz Simple Checking



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

Account Number: 8003204406 Date Opened: 08/03/2009 Opened By: Ryan Sherwood

Name and address:

Kula Hospital 100 Keokea Pl Kula, Hi Usa 96790

Owner(s) or Authorized Signer(s) Owner/Signer #1 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #2 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #3 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #4 name, title and address:

Primary ID issue entity: Primary ID issue date: Tax ID number: 99-0262276 Contact Information: Contact name: Contact title: Business phone: Established date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location. Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth; Primary ID type: Primary ID number: Primary ID issue location: Primary ID expiration date:

American Savings Bank New Account Information

8003204406

Beneficiary Designation.	The following beneficiary(ies) are designated:
1.	2.
З.	4.
Designation of Successor C	ustodian for HUTMA
1 Paul HARpere	0'Connur as custodian for KULAHOSPITAL under the Hawaii Uniform
Transfer to Minors Act I desi	nate the following as successor custodianPaul Harper-O'connor
Custodian: X Rault	Wilness by X Cligawin tax
	Name of wilness:

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.

× UGravita	Signer #1 name and title:	Nerissa Garrity, Aut
× Jane-7. Allagnt	Signer #2 name and title:	Jane Dellaport, Aut
× Cmity fay fine	Signer #3 name and title:	Ernette Kaea-Prones, Aut
× gegn Jaami	Signer #4 name and title:	Joyce Tamori, Aut

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Low commences and								
Under p	enalties of perjury, I	certify that:						
1. The	number shown on	this form is my correct taxpaye	r identification number (or I am w	aiting for a	number to be issued to me), and			
2, 1 arr	2. Lam not subject to backup withholding because: (a) Lam exempt from backup withholding, or (b) Lhave not been notified by the							
Internal	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 ar	m no longer subject to backup	withholding, and	•				
3.1am	a U.S. citizen or of	ther U.S. person (defined in the	e instructions)					
			ating that I am exempt from FAT	CA reportir	na is correct.			
Exe	motion from FATC/	A reporting code (if any)	NOT APPLICABLE					
Certific	ation instructions.	You must cross out item 2 abo	ove if you have been notified by th	e IRS ibal	you are currently subject to backup			
			nd dividends on your tax return.		for the advanty applet to protop			
Sign	Signature of	\cap .			0010010047			
Sign Here	Signature of U.S. person	UGarrita		Date 🏼	06/22/2017			
				1 Call P				

SIGNATURE CARD

ACCOUNT INFORMATION

Product Name: K

Kalo Simple Checking



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

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

Owner(s) or Authorized Signer(s) Owner/Signer #1 name, title and address:

Isamu Kajita 100 Keokea Pl Kula, Hi Usa 96790

Primary ID issue collig: State/County Government Primary ID issue date: 03/31/2011

Owner/Signer #2 name, title and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #3 name, titlo and address:

Primary ID issue entity: Primary ID issue date:

Owner/Signer #4 name, title and address:

Primary ID issue entity: Primary ID issue date: Tax ID number: <u>Contact Information</u>: Contact name: Contact Illis: Business phone: Established date:

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 localion: Hawaii Primary ID expiration date: 04/22/2012

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location: Primary ID axpiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number. Primary ID issue location: Primary ID expiration date:

Tax ID number: Date of birth: Primary ID type: Primary ID number: Primary ID issue location. Primary ID expiration date:

American Savings Bank New Account Information

8102676302

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

۴. 2 З.

Designation of Successor Custodian for HUTMA

1 Poul HARpen-a Cunne 12 as custodion Kula Hospitol Administetor under the Hawaii Unitorm

Transfer to Minors Act I designate the following as successor custodian: ____

Custodian: X Wilness by X Name of witness

4

To American Savings Bank ("ASB"): ASB is authorized to recognize any one of the signatures subscribed below in the payment and/or withdrawol 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

Chocking 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 cartification from the reliring signer reflecting the same.

x Cer Garrita	Signer #1 name and tille:	Nerissa Garrity, Aut
× Jane 7 Dellaport	Signer #2 name and title:	Jane Dellaport, Aut
× Contra Mais Minm	Signer #3 name and title:	Ernette Kaea-Prones, Aut
× pypulam	Signer #4 name and tille:	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 3.1 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 Signature of 06/13/2017 Garritz Date ► Here U.S. person

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		30038-52497		AMORIN, WINONA	TF	1,241.70
102		30038-52497		ANTONIO, HANNAH	TF	1,683.16
103		30038-52497		APOLIONA, JUDITH	TF	1,719.01
104		30038-52497		BAUGH, MARY LOU	TF	1,654.11
105	and the second	30038-52498		BAYBAYAN, CARLINA D	TF	31.63
106		30038-52497		BESCH, MICHAEL	TF	1,141.31
107	4/6/2014	30038-52497		DANG, MYRA	TF	130.26
108		30038-52497		DECAMBRA, JOSEPHINE	TF	1,604.58
109		30038-52497		ELKIN, EDWIN	TF	1,512,97
110	second states and states	30038-52497		ENGLISH, GORDON B	TF	49.01
111		30038-52497	2	ESTRELLA, MARY	TF	1,137.02
112		30038-52497		GIBSON, LESLEY	TF	585.41
113	12/3/2014	30038-52497	a dama in the month & some sides	GUSMAN, CARMEN	TF	880.01
114		30038-52497		HENSLEY, KRISTA JOY	TF	1,626.72
115		30038-52497		HENSLEY, SARAH JILL	TF	1,569.41
116		30038-52497		HEYER, ROBERT	TF	297.13
117		30038-52497		HIGA, SACHIKO**	TF	1,353.47
118		30038-52497		IDETA, ELLEN		1,430.23
119		30038-52497		ITO, ANN	TF	284.86
120	9/13/2016	30038-52497		ITO, JAMES	TF	651.60
121		30038-52497		KAHOOHANOHANO, KELLY	TF	1,732.68
122	5/13/2014	30038-52497		KAONA, RITA	TF	538.88
123		30038-52497		KEGLEY, LUCY	TF	1,922.43
124		30038-52497		KIM, BRENT	TF	172.08
125		30038-52497		KRATZMAN, STEPHANIE	TF	503.11
126		30038-52497			TF	1,247.03
127		30038-52497		KURISU, JANE T	TF	1,589,47
128	11/20/2013	30038-52497		LIND, DAISY M	TF	992.83
129		30038-52497			TF	1,651.76
130		30038-52497		MAKEKAU, JULIE	TF	18.56
131		30038-52497	and the second se	MALCOLM, GEORGIANA	TF	50.24
132		30038-52497		MARTIN, PAUL H		995.67
133		30038-52497		MAU, PEGGY	TF	137.44
134		30038-52497		MYLENEK, MARGARET	TF	502.33
135		30038-52497				1,742.13
136		30038-52498		NIKAIDO, ELTON	77	55.84
137		30038-52497		O'CONNOR, MARGARET	TF	1,427.99
138		30038-52497			TF	1,799.42
139		30038-52497		PUNIO, TERESA	TF	99.46 55 17
140		30038-52497		REDDY, RONALD	TF	55.17
141	stand for an Alternative statement and an	30038-52497		ROBERTS, REGINA	TF	58.68
142	<u> </u>	30038-52497		SANDERS, JENNIFER	TF	4,662.97
143		30038-52497		SOUZA, THOMAS	TF	185.82
144		30038-52497		STILES, ADELINE		1,827.10
145	<u></u>	30038-52497		SWINNERTON, THOMAS	TF	92.10
146	<u> </u>	30038-52497		TAMAYOSE, ROSS	TF	956,18

TRUST ASB FY17

147	ATTEL DE ATTELES AN AUGUST ANNO 1990	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	ale de la company
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
<u> </u>	I				50,250.56

Trust Checking Kajita 082016 FY17

		RECON BAL
	Account:	5/31/2017
PATIENT NAME		•
KAJITA ISAMU	81026-76302	1296.30
TOTAL		1298.30

Kula Hospital ATTENTION: <u>ADMINISTRATOR</u> 100 Keokea Place Kula, HI 96790

Er. A, Who Residenst Trust Fourts, # 3

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	e of Resident or Resident	t's legal repr	esentative	Date	
State of Hawaii County of Maui) :SS)					
·	day	of, , , , , to me l				
instrument in beh acknowledged that	alf of (s)he execu	ited the same as the fre				
NOTAR		CERTIFICATION				
Doc. Date:		# Pages:		Notour Dubl	a Stata of IIa	
Notary Name:		Judicial Circuit:			c, State of Hav e:	
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Notary Signature: _		·····	_	-		
Date:						

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· · · · · · ·		Account Number	T BE HELD IN Date Opened	Cuslomer		WNERS	
Account Type					Rev By	Dure Gr	
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8 1	Accept (etcpho	ne requests front any	I MMA	I	Check	ing	·Cust. Ink.
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E Transfers	Transfers Transfers Transfer I hereby revoke my request to transfer funds by telephone between the accounts listed in this Transfer I hereby revoke my request to transfer funds by telephone between the accounts listed in this						
and the second second	Revocation Date:						
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	Lanai Cit	<u>y, HI 96763</u>					
E Phone (808-565-8	450 Fax	Phone <u>808-56</u>	5-847	4		
		ntial Patient					
		erseding Date 05/03			No. of Ca	rds: <u>1</u>	of <u>1</u>
	- •						~ -
Name of Corpo	t Hawalian Ban	<u>k</u>	Corporation	on Acco		d ID Number	Lard
Lanai	Communit	y Hospital				-0262	19.1
Residu	ont Trust	Fund	above is my Sioner	ce of U,SJPa		·····	
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Constration und	ion, as well as intitat icrotances that the Ban	scoonst disclosures containing k will rely on information prov	ided on this card.		aa efdaticyoja		
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$\langle \rangle $	Ook-		¯(I)	1 of 1 24-019071 Account Name		U/1	
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M	· JAA		(2)	16	-	ar Trust	Fund
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arline Lorquias				X_Sup	New Acet. Reopened Acet. X Superseding Temporary Card		
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CM507 (REV. 7/1/1)							
(FRONT) SGCORP ** SPECIMEN SIGNATURE CARD							

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Account Comments:	•
Warnings:	•
Specimen Signature Card Special Instructions:	
Documentation Required to O	
Articles of Incorporation	On File ·
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Uni-CkExis Opened By Sally Review	
CORPORATE R	RESOLUTION OF AUTHORITY
"RESOLVED, that any (specify no.) of the	following (specify titles of individuals required to sign checks, etc.)
of this Corporation is (ars) authorized, on behalf of this Co	orporation and in its name, to sign bank checks and drafts for the withdraw solarcy of his Corporation; to sign, or otherwise make, requests and receipt is, notes, and other paper psyable to or by this Corporation; to walve proje ed by or to the order of this Corporation; and to enter into agreements will in the Bank. The bank of the order of the corporation in the order of the person signing the sen operation of such instrument or application of the person signing the sen opolit to his personal account, or tendered for cashing, and the Bank shall have or albeeting of the amount of any expenses and altorneys' fees insurred in cornel in the Bank is not at full. and becaute to or the consent of the Corporation or any of its officers, direc prior notice to rite consent of the Corporation or any of its officers, direc interfrom, the amount of any expenses and altorneys' fees incurred in cornel in the Bank is not at full. and Secretary shall certify to the Bank the names of the persons presently bol and immediately certify to the Bank any changes in the same, and the Bank sha may shall remain in full farce and effect until written notice of their amendance a bark has had a rensonable line to act thereon after its precipi. and Secretary be and he horeby is subtorized and directed to deliver a certified age resulting from any such relinee. There cony of the Resolutions, duly adopted by the Band of Directors of (Nam (the Corporat
funds, drawn on First Hawallan Bank (the "Bank") as a depo the withdrawd of Runds; to indorse and accept checks, drafts	ository of this Corporation; to sign, or otherwise make, request and receipt is, notes, and other paper payable to or by this Corporation; to waive prote and bu or to the order of this Corporation; and to enter the determined with
Bank relative to the account or accounts of this Corporation I FURTHER RESOLVED, that the Bank be and it here	in the Bank. etby is authorized to honor, receive, pertify, or pay all instruments and requ
signed or made in accordance with the foregoing Resolution tendered in payment of his individual obligation, or for dep	a even though drawn or indersed to the order of the person signing the sent sosit to his personal account, or tendered for cashing, and the Bank shall have a disactive of the latternal or andication of the necessary disaction.
"FURTHER RESOLVED, that the Bank may, without p or sharcholders, yet off sgainst the scoount(s) and induct th	prior notice to or the consent of the Corporation or any of its officers, direct herefrom, the amount of any expenses and storneys' fees incurred in costs
with any dispute or fitigation involving this account(s) in whe FURTHER RESOLVED, that the Secretary or Assistant	tich the Bank is not at fault. But Secretary shall certify to the Bank the names of the persons presently hol by improve that the the Bank shall say change in the same and the Bank sha
fully protected is relying on such certification. FURTHER RESOLVED, that the foregoing Resolution	as shall remain in full force and effect until written notice of their amendment
revocation shall have been received by the Bunk and until the FURTHER RESOLVED, that the Secretary or Assistant	s Bank has had a rensonable time to act thereon after its recenpt. In Secretary be and he hereby is suthorized and directed to deliver a certified
FURTHER RESOLVED, that the Bank shall be fully harmless from any claims, demands, expenses, loss, or dama	y protected in relying on these resolutions, and shall be indemnified and a spectrosulting from any such reliance.
Thereby certify that the foregoing is a full, true, and con Corporation	irrect copy of the Resolutions duty sampled by the Board of Directors of (rem
at a meeting duly and regularly called and held on $\frac{104}{4}$	26/2010, or by such resolution unanimously adopted by where 10 ; that such resolutions are duly recorded and appear in the micute
of the Corporation and have not been altered, amended, no	or revoked; and that the foregoing specimen signatures appearing on the re
IN WITNESS WHEREOF, I have harounto subscrib	bed my name and a fixed the seal of said Corporation this $\underline{26th}$ di
CM-507 (REV. 7/1/01) (BACK) SGCORP **	Sochusor or Assistant Secretary
	ILY
FOR BANK USE ON	
Special Instructions: (A	Maximum 149 Positions)
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CM-507 (REV. 711.01) (BACK) SCCORP **

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HAWAII HEALTH SYSTEMS STATE OF HAWAII Trucking Unreaders/Normal State OF HAWAII Trucking Unreaders/Normal Trucking Unreaders/Normal Trucking Unreaders/Normal Patient Name: Review Dervice MR # LIOSTIPO2 So long as (patient/resident's name), Review Eskawan, Sr. ("patient/resident') remain a patient/resident at LANAI COMMUNITY HOSPITAL ("Hospital"), Thereby authorize the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident. In order to facilitate bip 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 myline patient/resident's account and to pay medical bills, funds are to be disbursed to myline on request. Upon death and after payment of any outstanding medical bills, funds are to be disbursed to myline patient/resident's: (-) personal representative (-) (-) personal represe	, *	
Patient Name: Reuber: Eskeren Sr. MR# UI0319902 So long as I (patient/resident's name). Reuber: Eskeren Sr. (rpatient/resident') remain a patient/resident at LANAI COMMUNITY HOSPITAL ("Hospital"), Thereby 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 () legal guardian () payer's name: Barbaara A. Eskeran Payee's address: Po Dox Gooton Telephone #: (SOG) Eds - GUI1 (H) sog - Eds - 1251 (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: Butant M. Katuan Date: 8/118/15 Signature: Butand M. Mobleculu Date: 8/1	HAWAII HEALTH S C O R P O R STATE OF HAWAII	
MR # U007199.2 So tong as I (patient/resident's name), ("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 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:		
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to me from: for the purpose of removing checks to be deposited into my/the patient/resident's account and to pay medical bills. 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 () designated beneficiary () power of attorney () legal guardian Payee's name: Barbarra A. Eskaran Payee's address: PO Rox (2007) Telephone #: (200) BAS - CUIT (H) 808 - 50-2-1351 (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: Burbar A. A. A. Skaran Payee's name: Rox (2007) Witnessed by: Well AMM MARAWA Witnessed by: Well AMM MARAWA Witnessed by: Well AMM MARAWA Notary Public State of Hawaii, 2004 My commission expires: 21/1/2 / 2.6.12 Notary Public State of Hawaii, 2004 My commission expires: 21/1/2 / 2.6.12 Notary Public State of Hawaii, 2004 My commission expires: 21/1/2 / 2.6.12 Notary Public CERTIFICATION My commission expires: 21/1/2 / 2.6.12 Notary Public CERTIFICATION	("patient/resident") remain a patient/resid authorize the Hospital to open and main	dent at LANAI COMMUNITY HOSPITAL ("Hospital"), I hereby
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Payee's address: PO Box 02000T I Loroni City, H1 90703 Telephone #: (808) 808 - 6017 (H) 808-5603-1351 (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: Bathan, D. Rockum Date: 08 1 18 1 / S Relationship to Patient: Sponge Date: 08 1 18 1 / S Witnessed by: Witnessed by: Wallam MMA WW Date: 8 / 18 1 / S Subscribed and Sworn to before me this In the year 20/S I with commission expires: 2/19 / 20 / 6 NOTARY PUBLIC CERTIFICATION Second Judicial Circuit My commission expires: 2/19 / 20 / 6 No of Pages: Date of Doc. Interfect Mathematical Circuit No of Pages: Date of Doc. Interfect Mathematical Circuit	patient/resident's: () personal representati	
Lansi City, H1 96763 Telephone #: Lansi City, H1 96763 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: Barbana A. Fakuman Date: 08118 18115 Witnessed by: Witnessed by: Barbana M. Fakuman Date: 8/18 9015 Subscribed and Sworn to before me this In the year 2015 Date: 8/17 19015 My commission expires: 2/19/2016 NOTARY PUBLIC CERTIFICATION Second Judicial Circuit My commission expires: 2/19/2016 NOTARY PUBLIC CERTIFICATION Marcan And Judicial Circuit NOTARY PUBLIC CERTIFICATION My commission expires: 2/19/2016 NOTARY PUBLIC CERTIFICATION My commission expires: 2/19/2016 NOTARY PUBLIC CERTIFICATION Mo of Pages: Date of Doc. Interact Model My commission Start Funct My commission 2/19/2016 No of Pages: Date of Doc. Interact	· · · · · · · · · · · · · · · · · · ·	
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: <u>Barbara A. Fockum</u> Date: <u>08118115</u> Relationship to Patient: <u>Sponce</u> Witnessed by: <u>Barbara M. Kockum</u> Date: <u>8/118175</u> Witnessed by: <u>Barbara M. Kockum</u> Date: <u>8/118175</u> Subscribed and Sworn to before me this <u>18</u> Day of <u>Austral</u> in the year <u>2015</u> <u>1000000000000000000000000000000000000</u>	Lan	ai City, H1 96763
purpose is to permit the Hospital to open and maintain a Trust Fund account on my behalf/on behalf of the patient/resident. Signature: <u>Barban A. Fokum</u> Date: <u>08118115</u> Relationship to Patient: <u>5 Porce</u> Witnessed by: <u>Wellaw MWCALWW</u> Date: <u>8/118 19015</u> Witnessed by: <u>Wendolph Wodelcource</u> Witnessed by: <u>Wendolph Wodelcource</u> Subscribed and Sworn to before me this <u>18" Day of <u>August</u> in the year <u>Date:</u> <u>8118 126172</u> Subscribed and Sworn to before me this <u>18" Day of <u>August</u> in the year <u>Date:</u> <u>10m/M-</u> Notary Public State of Hawali, <u>2nd</u> Judicial Circuit My commission expires: <u>2/19 por 6</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u> <u>10m/M-</u></u></u>		, · · / · · · · · · · · · · · · · · · ·
Relationship to Patient: <u>Sponse</u> Witnessed by: <u>Harder Model with</u> Date: <u>8/118 19015</u> Witnessed by: <u>Karder Model with</u> Date: <u>8/118 19015</u> Subscribed and Sworn to before me this <u>18 Day of <u>August</u> in the year <u>2015</u> <u>10/11/9-</u> Notary Public State of Hawali, <u>2 not</u> Judicial Circuit My commission expires: <u>2/19/2016</u> <u>10/19/2016</u> <u>10/19/2016</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u> <u>10/101</u></u>	purpose is to permit the Hospital to open and maintain	
Witnessed by: <u>Handalah Modulut</u> Date: <u>8/118</u> 19015 Witnessed by: <u>Handalah Modulut</u> Date: <u>8/118</u> 19015 Date: <u>8/118</u> 19015 Subscribed and Sworn to before me this <u>18' Day of <u>August</u> in the year <u>2015</u> <u>10'M</u>-<u>W</u> Notary Public State of Hawali, <u>2 not</u> Judicial Circuit My commission expires: <u>2/19/2016</u> <u>19/016</u> NOTARY PUBLIC CERTIFICATION Jerrilyn Yumol Second Judicial Circuit Doc Description: <u>Lanau Community</u> <u>Hospiral</u> <u>Trust Funct</u> <u>No of Pages: 1</u> Date of Doc. <u>Invatate</u> <u>10'M</u>-<u>W</u> <u>10'M</u>-<u>W</u> <u>10'M</u>-<u>W</u> <u>10'M</u>-<u>W</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u>-<u>M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> <u>10'M</u> </u>		
Image: Public State of Hawali,	Witnessed by:	Machun Date: 8/118, 18015
Notary Public State of Hawaii, 2/19/2016 My commission expires: 2/19/2016 Notary Public CERTIFICATION Jerrilyn Yumoi Second Judicial Circuit Boc, Description Lana, Community Hospital Trust Funct Account Agreements No of Pages: Date of Doc. Lindattot Image: 1 State of Judicial Circuit 1	1 21-	in the year
Doc, Description: Lana, Community Hospital, Trust Fund Account Agreement No of Pages: 1 Date of Doc. Lindated [CM/4] V 8/18/2015	Notary Public State of Hawali, 200	NOTARY PUBLIC CERTIFICATION
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		No of Pages: Date of Doc. Lindahoc

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Lanai Community Hospital 628 Seventh Street Lanai City, HI 96763

Patient Trust Fund Statement

Reuben Eskaran PO Box 630650

Patient Name: Reuben Eskaran

Lanai City, HI 96763

For Period May 01, 2017 to Ending May 31, 2017 Account Summary:

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

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 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

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"Tonohing Lives Bweyday"

TRUST FUND ACCOUNT AGREEMENT

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	Walter D Y Inchi-		
to long as I (patient/resident's name), "patient/resident") remain a patient/res nuthorize the Hospital to open and main			
n order to facilitate this process, I furth	ter authorize the Hospital to or	en any first class	mail addressed to me fron
for the purpose of removing checks to h understand that a summary of transact equest.			
Jpon death and after payment of any or patient/resident's:	utstanding medical bills, funds	are to be disburs	ed to my/the
() personal representation() power of attorney	ative	() designa() legal g	ated beneficiary uardian
Payee's name:			
Payee's address:			
Telephone #:			
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know of no reason which prevents me	the patient/resident from enter in a Trust Fund account on my	ring into this agre behalf/on behalf	ement which purpose is to
ermit the Hospital to open and mainta	withe patient/resident from enter in a Trust Fund account on my N	behalf/on behalf	of the patient/resident.
Bignature:	o/the patient/resident from ente in a Trust Fund account on my	behalf/on behalf	cement which purpose is to of the patient/resident. /19/2013
Signature:	o/the patient/resident from ente in a Trust Fund account on my	behalf/on behalf	of the patient/resident.
Signature:	o/the patient/resident from ente in a Trust Fund account on my	behalf/on behalf	of the patient/resident.
Bignature: When and maintain Relationship to Patient: Self Witnessed by:	o/the patient/resident from ente in a Trust Fund account on my	behalf/on behalf Date:2 Date;2	of the patient/resident.
Bignature:	b/the patient/resident from ente in a Trust Fund account on my b b m b b m b m b m b m b m b m b m b	behalf/on behalf Date:2 Date;2	of the patient/resident.
ermit the Hospital to open and maintai ignature: lelationship to Patient: Self Vitnessed by: H& Pont Vitnessed by: Louine G	in a Trust Fund account on my	behalf/on behalf Date:2 Date;2	of the patient/resident.
Algorithmeter Hospital to open and maintain Alignature: Mathematical Relationship to Patient: Self Witnessed by: HSA Cont Witnessed by: Youring G Subscribed and Sworn to before me this Day of	in a Trust Fund account on my	behalf/on behalf Date:2 Date;2	of the patient/resident.
Subscribed and Sworn to before me this Day of	in a Trust Fund account on my	behalf/on behalf Date:2 Date;2	of the patient/resident.
I know of no reason which prevents me permit the Hospital to open and maintain signature: Signature: Image: Self self self self self self self self s	in a Trust Fund account on my	behalf/on behalf Date:2 Date;2	of the patient/resident.

PHONE: (808) 565-6411 . FAX: (808) 565-6887

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Lanai Community Hospital 628 Seventh Street Lanat City, HI 96763

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Patient Trust Fund Statement

Walter Lischka PO Box 630650	Patient Name:	Walter Lischka
Lanal City, HI 96763	•	
For Period May 01, 2017 to Ending May 31, 2017		
Account Summary:		
Beginning Balance .PLUS:		1,179.06
Deposits Interest Earned	2,475.07	2,475.07
Less:		3,654.13
Cost Share Other	2,168.00 10.00	<u>2,178.00</u>
Ending Balance	Ferra	Ale76.113

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 in you personal funds. If you have any questions about your statement, please call Business Office at 733-7927.