PURSUANT TO ORDER ENTERED BY THE UNITED STATES BANKRUPTCY COURT, CENTRAL DISTRICT OF CALIFORNIA, ON NOVEMBER 13, 2007, DOCKET No. 1092
PUBLIC ACCESS TO THIS CLAIM IS RESTRICTED

THIS PROOF OF CLAIM IMAGE HAS BEEN SUPPRESSED TO PROTECT THE CLAIMANT'S CONFIDENTIAL INFORMATION.

UNITED STATES BANKRUPTCY COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

PROOF OF CLAIM

FILED
JAN 18 2006
CLERK U S BANKRUPTCY COURT
CENTRAL DISTRICT OF CALIFORNIA
BY Deputy Clerk

In re
WATTSHealth Foundation, Inc , dba UHP Healthcare, a California not-for-profit corporation

Case Number
LA 05-22627-TD

NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case A "request" for payment of an administrative expense may be filed pursuant to 11 U S C § 503

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim Attach copy of statement giving particulars

☒ Check box if you have never received any notices from the bankruptcy court in this case

☐ Check box if this address differs from the address on the envelope sent to you by the court

Name of Creditor and Address

Country Villa Nursing & Rehabilitation Cntr
340 S Alvarado Street
Los Angeles, CA 90057

Creditor Telephone Number ( ) 213-484-9730

THIS SPACE IS FOR COURT USE ONLY

Account or other number by which creditor identifies debtor
95-4301174

Check here if this claim ☐ replaces ☐ amends a previously filed claim dated _____

1 BASIS FOR CLAIM

☐ Goods sold
XXX Services performed
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
☐ Other (describe briefly) _____
☐ Retiree benefits as defined in 11 U S C § 1114(a)
☐ Wages salaries and compensation (Fill out below)
Last four digits of SS # _____
Unpaid compensation for services performed from _____ (date) to _____ (date)

2 DATE DEBT WAS INCURRED 3/2002-5/2002

3 IF COURT JUDGMENT, DATE OBTAINED

4 Total Amount of Claim at Time Case Filed
Amount of Claim Listed on Debtor's Schedules
(Excludes any contingent, unliquidated and disputed amount)

$	(unsecured)	(secured)	(priority)	(Total)
	6385.92	N/A	N/A	6385.92

Amount of Claim Asserted by Creditor
(To be completed if creditor disputes scheduled amount)

$	(unsecured)	(secured)	(priority)	(Total)

☐ Check this box if claim includes interest or other charges in addition to the principal amount of the claim Attach itemized statement of all interest or additional charges If all or part of your claim is secured or entitled to priority also complete Item 5 or 7 below

5 SECURED CLAIM

☐ Check this box if your claim is secured by collateral (including a right of setoff)

Brief description of collateral

☐ Real Estate ☐ Motor Vehicle
☐ Other _____

Value of Collateral $ _____

Amount of arrearage and other charges at time case filed included in secured claim if any $ _____

6 UNSECURED NONPRIORITY CLAIM $ _____

☐ Check this box if a) there is no collateral or lien securing your claim or b) your claim exceeds the value of the property securing it or if c) none or only part of your claim is entitled to priority

7 UNSECURED PRIORITY CLAIM

☐ Check this box if you have an unsecured priority claim

Amount entitled to priority $ _____

Specify the priority of the claim

☐ Wages salaries or commissions (up to $10 000)* earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business whichever is earlier 11 U S C § 507(a)(3)
☐ Contributions to an employee benefit plan 11 U S C § 507(a)(4)
☐ Up to $2 225* of deposits toward purchase lease or rental of property or services for personal family or household use 11 U S C § 507(a)(6)
☐ Alimony maintenance or support owed to a spouse former spouse or child 11 U S C § 507(a)(7)
☐ Taxes or penalties owed to governmental units 11 U S C § 507(a)(8)
☐ Other Specify applicable paragraph of 11 U S C § 507(a) (____)

Amounts are subject to adjustment on 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

8 CREDITS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim

9 SUPPORTING DOCUMENTS *Attach copies of supporting documents,* such as promissory notes purchase orders invoices itemized statements of running accounts contracts, court judgments mortgages security agreements and evidence of perfection of lien DO NOT SEND ORIGINAL DOCUMENTS If the documents are not available explain If the documents are voluminous attach a summary

10 DATE-STAMPED COPY To receive an acknowledgment of your claim, please enclose a self-addressed, stamped envelope and an additional copy of this proof of claim (signed face page only).

The original of this proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is actually received on or before 4 00 P M prevailing Pacific Time on January 31, 2006

BY MAIL TO WATTSHealth Foundation Inc dba UHP Healthcare
United States Bankruptcy Court
PO Box 53229
Los Angeles CA 90053 0229

THIS SPACE FOR COURT USE ONLY

REC'D JAN 30 2006

WATTSHealth Foundation Inc dba UHP
CLAIM 00579

DATE SIGNED
12/30/2005

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)
Anna Farrar
Director A/R & Field Acctg

Penalty for presenting fraudulent claim is a fine of up to $500 000 or imprisonment for up to 5 years or both 18 U S C §§ 152 AND 3571

New Medical Claim Summary

Creditor Name Country Villa Nursing & Rehab
Facility Name Country Villa Nursing & Rehab
Provider Tax ID 95-4301174

Reference Number	Provider Name	Provider Claim Number	Member Number	Plan Type	Patient SSN	Patient Last Name	Patient First Name	Patient Date of Birth	Start DOS	End DOS	Gross Charges - Provider	Amount Paid per Provider	Balance Due per Provider
1	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/29/2002	3/31/2002	$101 37	$0 00	$101 37
2	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/1/2002	5/7/2002	$193 62	$0 00	$193 62
3	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/8/2002	5/14/2002	$193 62	$0 00	$193 62
4	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/15/2002	5/21/2002	$193 62	$0 00	$193 62
5	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/22/2002	5/28/2002	$193 62	$0 00	$193 62
6	Country Villa Nursing & Rehab	Unknown	794431	Medicare	410405469	Overstreet	Rosiemary	10/4/1922	5/29/2002	5/31/2002	$78 07	$0 00	$78 07
7	Country Villa Nursing & Rehab	Unknown	402702	Med/Supp	419506021	Floyd	Ethel	2/11/1928	6/6/2000	6/30/2000	$2,425 00	$0 00	$2,425 00
8	Country Villa Nursing & Rehab	Unknown	402702	Med/Supp	419506021	Floyd	Ethel	2/11/1928	7/1/2000	7/31/2000	$3,007 00	$0 00	$3,007 00
													$6,385 92

COUNTRY VILLA NURSING CTR 340 S ALVARADO ST LOS ANGELES CA 90057 213 4849730 X 0000	2	3 PATIENT CONTROL NO HM04522H05 03	4 TYPE OF BILL 221						
	5 FED TAX NO 954301174	6 STATEMENT COVERS PERIOD FROM 032902 THROUGH 033102	7 COV D	8 N-CD	9 CID	10 LRD	11		

12 PATIENT NAME	13 PATIENT ADDRESS
OVERSTREET ROSIEMARY	340 S ALVARADO ST LOS ANGELES CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24	25	26	27	28	29	30	31
10041922	F	S	92801					30									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A B C

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
WATTS HEALTH FOUNDATION UHP HEALTHCARE PO BOX 90579 LOS ANGELES CA 90009 ~~(800) 544-0035~~ (800) 698-2016	a					
	b					
	c					
	d					

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
270	SUPPLIES PUMP KIT	B4034	032902	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	032902	1	9 79		
270	SUPPLIES PUMP KIT	B4034	033002	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	033002	1	9 79		
270	SUPPLIES PUMP KIT	B4034	033102	1	13 26		
270	ENT CATEGORY 1 SYN	B4150	033102	1	9 56		
290	PUMP RENTAL	B9000	032902	1	4 39		
290	PUMP RENTAL	B9000	033002	1	4 39		
290	PUMP RENTAL	B9000	033102	1	4 13		
300	BLOOD GLUCOSE TEST	82962	032902	2	6 46 ✓		
300	BLOOD GLUCOSE TEST	82962	033002	2	6 46 ✓		
300	BLOOD GLUCOSE TEST	82962	033102	2	6 46 ✓		
001	TOTAL				101 37		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
UHP MEDICARE/LA VIDA	555397	Y	Y		101 37	
57		DUE FROM PATIENT ▶				

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
OVERSTREET ROSIEMARY	1	410405469A		794431
OVERSTREET ROSIEMARY	1	4104054691		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
SEE MD ORDERS			

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E CODE	78
486	25000	7872	436	34290							

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE COD	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID
F23172 CHOI SEUNG HO
83 OTHER PHYS ID
OTHER PHYS ID
85 PROVIDER REPRESENTATIVE X — 86 DATE

84 REMARKS PART B OUTPATIENT SERVICES

COPY

FORM HCFA 450 APPROVED OMB NO 0938 0279 — OCR/ORIGINAL — I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Resident's Name OVERSTREET ROSIE MAE

Month / Year MARCH 2002

Physician Order for Blood Glucose Monitoring

Room # 3193

Resident # 402200

Date	Time	Results	Digit	RN / LVN Signature
3/1/02	6A	10	L	[illegible]
3/2/02	6AM	134	R-2	AW
3/3	6A	124	L	[illegible]
3/4	6A	113	L	[illegible]
3/5	6A	110	L	[illegible]
3/6	6A	98	L	[illegible]
3/7	6A	101	L	[illegible]
3/8	6A	118	L	[illegible]
3/9	6A	124	L	[illegible]
3/10	0600	120	R-3	[illegible]
3/11	6A	111	L	[illegible]
3/12	6A	101	L	[illegible]
3/13	6A	115	L	[illegible]
3/14	6A	108	L	[illegible]
3/15	6A	106	L	[illegible]
3/16	6A	100	L	[illegible]
3/17	6A	101	L	[illegible]
3/18	6A	96	L	[illegible]
3/19	6AM	135	R-3	AW
3/20	6A	111	L	[illegible]
3/21	6A	98	L	[illegible]
3/22	6A	124	L	[illegible]
3/23	6A	100	L	[illegible]
3/24	0600	108	L-1	[illegible]
3/25	0600	91	R-1	[illegible]
3/26	6A	98	L	[illegible]
3/27	6A	108	L	[illegible]
3/28	6A	96	L	[illegible]
3/29	6A	101	L	[illegible]
3/30	6A	100	L	[illegible]
3/31	6A	98	L	[illegible]

Date	Time	Results	Digit	RN / LVN Signature
3-1-02	[illegible]	[illegible]	R2	[illegible]
3/2/02	430PM	159	R-3	AW
	4:30	168	R2	[illegible]
3/4/02	434	132	R1	[illegible]
3/5/02	434	147	R2	[illegible]
3/6/02	434	87	R3	[illegible]
3/7/02	434	104	R4	[illegible]
3/8/02	430	130	R1	J. Morgan
3/9/02	430	146	R1	J. Morgan
3/10/02	434	122	L5	[illegible]
3/13/02	434	97	L4	[illegible]
3/14/02	434	89	L3	[illegible]
3/15/02	434	141	L2	[illegible]
3-16-02	430	108	R3	S Tremoin LVN
3/17/02	434	119	R1	[illegible]
3/18/02	434	122	R2	[illegible]
3/19/02	434	129	R3	[illegible]
3/20/02	434	120	R4	[illegible]
3-21-02	4:30	138	R2	[illegible]
3/22/02	434	101	L5	[illegible]
3/23/02	434	72	L4	[illegible]
3/24/02	434	112	L3	[illegible]
3/25/02	434	100	L	AW
3/26/02	434	72	R5	[illegible]
3/27/02	430	118	R4	[illegible]
3/28/02	430	120	R7	[illegible]
3/29/02	430	98	R2	[illegible]
3/30/02	430	100	R1	J. Morgan
3/31/02	430	93	R-3	AW

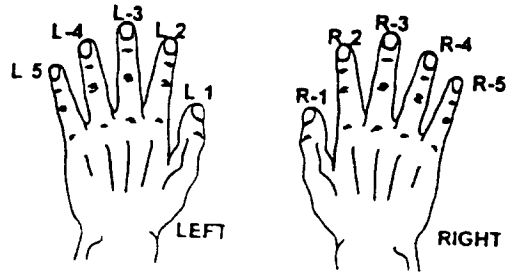
*Insulin Administration to be documented on Medication Record

KEY

LEFT HAND (Thumb to small finger)
L-1, L-2, L-3, L-4, L 5)

RIGHT HAND (Thumb to small finger)
R-1 R 2, R-3, R-4 R 5)

62



FACILITY COUNTRY VILLA NURSING & REHAB MARCH 2002 CHART COPY

PHYSICIAN'S ORDERS

	ORDER #	ORDER DATE	CODE	ORDERS	ADM TIMES
**				GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	**
				CONTINUED PAGE 3	
		9/28/01		LUE RESTING HAND SPLINT BY CNA QD X 6-8 HRS AS TOLERATED 7X WEEK	
**				ABOVE ORDERS APPROVED FOR 45 DAYS UNLESS OTHERWISE SPECIFIED	**
				DOCTOR SIGNATURE ---/---/--- DATE	
				NURSE SIGNATURE DATE 3/5/02	
				RECAP CHECKED BY DATE 2/25/02	
		3/3/02		pulse ox 5 min Call MD if 90%	
		5 10 pm		Chest x-ray Stat Call MD	
				done 3-3-02 jessi	
				TO DR. Washington / DR Choi	
		3-3-02 10 PM		Q at 2 L/Nas nc continuously	
				Reclast 1 gram IVPB q 24° q 1 week	
				flagyl 500 mg IVPB q 8° q 1 week	
				call DR choi in AM and notify him about ABG's and duration To: DR choi / DR washington / Keep VA	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
1/21/95	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
CHOI, SEUNG HO	213-207-5010		

DIAGNOSIS		ALLERGIES
PNEUMONIA	CVA	NO KNOWN ALLERGIES
DM	(L) HEMIPLEGIA	
DYSPHAGIA WITH G-TUBE PLA	HYPERTENSION	

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
MEDI-CAL	4522-00	53	0319	2	F	OVERSTREET ROSIE MARY	3

FACILITY COUNTRY VILLA NURSING & REHAB MARCH 2003 CHART COPY

PHYSICIAN'S ORDERS

	ORDER #	ORDER DATE	CODE	ORDERS	ADM TIMES
**				GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED.	**
				* CONTINUED - PAGE 2 *	
		9/28/01	P	TYLENOL 325 MGS TAB 2 GASTROSTOMY TUBE EVERY 24 HOURS PRN TEMP > 100.5 DEGREES OR ABOVE CALL MD	PRN
				********** TREATMENT **********	
		9/28/01		G- TUBE SITE: CLEANSE W/ NS COVER W/ DD DAILY	QDTX
		9/28/01		FLEETS ENEMA EVERYDAY PRN FOR SEVERE CONSTIPATION IF MOM INEFECTIVE	PRN
		9/28/01		OXYGEN AT 3 LITERS/MIN. PER NASAL CANNULA AS NEEDED FOR SOB	PRN
		9/28/01		G TUBE 16FR/15CC CHANGE PRN FOR MALFUNCTION OR PULLED OUT . EVERYDAY PRN	PRN
				********** RESTRAINT **********	
		9/28/01		SIDE RAILS UP (2) AND LOCKED WHILE IN BED FOR SAFETY AND PROTECTION	
		9/28/01		LAP BUDDY WHEN UP IN W/C FOR SAFETY	
				RELEASE 02 HRS X 10 MINS FOR REPOSITION	
				********** OTHER ORDERS **********	
		9/28/01		ORAL CARE Q2HRS BY LICENSED NURSE	
		9/28/01		ACTIVITY PLAN REVIEWED AND APPROVED AND NOT IN CONFLICT WITH TREATMENT PLAN TO TOLERANCE QD	
		9/28/01		HEAD OF BED ELEVATED AT 30-45 DEGREES AT ALL TIMES	
		9/28/01		DILANTIN LEVEL Q MONTHLY	

* CONTINUED ON NEXT PAGE *

7/4/01 Medications Reconciled Pharmacist Flagyl Rocephin 1 gm IVPB q 24 x 1 week

7/4/01 Flagyl 500mg IVPB q 8° x 1 week noted T.O. Dr. Chai A. Angeles

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
7/21/95	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
HUI, SEUNG HO	213-207-5010		

PNEUMONIA DIAGNOSIS CVA NO KNOWN ALLERGIES

M (L) HEMIPLEGIA

YSPHAGIA WITH G-TUBE PLA HYPERTENSION

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
EDI-CHG	4522 00	33	0319	2	F	OVERSTREET ROSIE MARY	2

FACILITY COUNTRY VILLA NURSING & REHAB MARCH 2002 CHART COPY

PHYSICIAN'S ORDERS

ORDER #	ORDER DATE	CODE	ORDERS	ADM TIMES
**	GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED			**
**********			DIET **********	
	11/13/01		RESOURCE DIABETIC PROVIDE (1210CC/1283KCALS) PER 22 HRS WITH PUMP & EQUIP SET PUMP RATE AT 55CC/HR. 76 GRAMS	
**********			MEDICATION **********	
	9/28/01	G	FLUSH G-TUBE WITH 200CC H20 & FLUSH G-TUBE W/ 50CC H20 BEFORE & AFTER TUBE FEEDING ADMINSTRATION . EVERY SIX HOURS	Q6H
	9/28/01	G	CHECK & RECORD RESIDUAL AND HOLD FEEDING X1HR IF ABOVE 100CC QSHIFT	QS
	12/31/01	I	FINGER STICK . FINGER STICK TWICE A DAY W/SLIDING SCALE COVERAGE WITH REGULAR INSULIN <150=0>151-200 =2"U >201-250=4 U >251-300=6"U 300=8'UNITS	FSBID
	9/28/01	M	MULTIVITAMIN WITH MINERALS 5CC GASTROSTOMY TUBE DAILY	QD
	9/28/01	M	COLACE 100MG/10CC GASTROSTOMY TUBE DAILY	QD
	9/28/01	M	ASA 325 MG GASTROSTOMY TUBE DAILY FOR {CVA}	QD
	9/28/01	M	VASOTEC TABLETS 10 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS HOLD IF BP BELOW 120	Q12H
	9/28/01	M	CLONIDINE 0.2 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS (CATAPRES)	Q12H
	9/28/01	M	NITROGLYCERIN OINT 2% 1 INCH THREE TIMES A DAY TO CHEST WALL	TID4
	9/28/01	F	BLOOD PRESSURE, EVERY WEEK MONITOR FOR (VASOTEC)	QWK
**********			PRN MEDICATION **********	
	9/28/01	P	MOM 30CC GASTROSTOMY TUBE EVERYDAY PRN FOR CONSTIPATION	PRN
			* CONTINUED ON NEXT PAGE *	
	recapped 2/5/02		Pilastin 125mg via G tube BID	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
7/21/95	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
CHOI, SEUNG HO	213-207-5010		

DIAGNOSIS		ALLERGIES
NEUMONIA	CVA	NO KNOWN ALLERGIES
OM	(L) HEMIPLEGIA	
DYSPHAGIA WITH G-TUBE PLA	HYPERTENSION	

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
MEDI-CAL	4522-00	S3	0319	2	F	OVERSTREET ROSIE MARY	1

HMO/Medicare Risk Insurance Verification Form

(Separate forms should be completed for Part A & Part B Claims)

Resident Information

Resident Name ROSEMARY OVERSTREET SS # 440-40-1469

Date of Admit 7/21/1995

Circle the type of claim that this verification is good for: HMO Part A HMO Part B

Insurance Information

Name of Insurance UHP

Resident Insurance ID# 794431 Insurance Policy #

IPA/Medical Group Name USC UNIV AFFILIATES

Payor Information

(This is where to mail the claim for payment based on type of service)

Name of Payor WATTS HEALTH FOUNDATION

Street Address UHP HEALTH CARE

PO BOX 90099 LA CA 90009

(City) (State) (ZIP)

Attn CLAIMS DEPT

Payor Claims Department Phone Number 800 624-0088

Eligibility/Benefits Information

Name of person at Ins Co who is supplying information TINA

Phone # of person at Ins Co who is supplying information 800-648-3016

Effective Date of Policy 11/01/94 Is policy still in effect? Y N

If no date of policy termination _____ (If no stop here There is no coverage)

Does policy cover Inpatient Skilled Nursing Services? Y N

What is the maximum number of days covered under SNF? _____

What is the maximum dollars payable under SNF benefits? _____

If there are limited days and dollars how many days are currently still available to the resident? _____ How many dollars are available? _____

HMO/Medicare Risk Insurance Verification Form

Does the insurance company require an authorization or tracking number? Y N

If yes what is the authorization/tracking number for this admit? _____

Does the policy cover Medicare allowable Part B' services? Y N
(Note You must obtain an authorization for all Part B' services prior to supplying the services)

IPA/Medical Group Information

Name of IPA/Medical Group USC UNIV AFF

Name of person at IPA/Med Grp supplying information _____

Phone # of person at IPA/Med Grp supplying information _____

Does the IPA require a tracking referral or authorization number? Y N

If yes what is the number? _____
(Note Facility Case Manager or designated person must continue to monitor these cases and obtain extended authorizations as needed to cover all SNF days)

Case Management

Name of Company handling Case Management _____

Contact Name _____ Phone # _____ Fax # _____

Additional Information

Comments PART-B GT FEEDINGS

Attachments Required With Billing

[ ] UB92
[ ] Authorization
[ ] Invoices for Exclusions
[ ] Other _____

Insurance Verification

Completed By [signature] Date 9/10/01

Health Insurance

SOCIAL SECURITY

NAME OF BENEFICIARY

ROSIE MARY OVERSTREET

CLAIM NUMBER

410-40-5409-A

SEX

FEMALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE 10-1-67

MEDICAL INSURANCE 10-1-67

SIGN HERE Rosie Mary Overstreet

```
        HIQACRO     CWF  PART A  INQUIRY REPLY                          PAGE 01 OF 06
IP-REC  CN 410405469A      NM OVERST    IT R    DB 10041922    SX F      IN 52280
PN 555397      APP          REAS 1         DATETIME 040402 090820  REQ A009
DISP-CODE 01    MSG UNCONDITIONAL ACCEPT
CORRECT     410405469A      NM           IT      DB             SX
A-ENT 100187 A-TRM 000000 B-ENT 100187 B-TRM 000000 DOD 000000 LRSV 60 LPSY 190

DAYS LEFT FULL-HOSP CO-HOSP FULL-SNF CO-SNF  IP-DED BLOOD  DOEBA   DOLBA
CURRENT       60       30       20       80   81200    3    000000  000000
PRIOR
PARTB YR 02 DED-TBM 10000 BLD 3 YR 01 DED-TBM 00000 BLD 3       DI 1000020000
FULL-NAME OVERSTREET ROSIE MARY
HMO       CURR ID H9016 OPT C ENR 110194 TERM 000000
PER 4    PRIOR ID H9104 OPT C ENR 040194 TERM 103194


PART A YR       BLD  3
CATASTROPHIC A     DED-TBM BLOOD CO-SNF  FULL-SNF  DOEBA  DOLBA  DED-APL
YEAR   89          0056000   03   008     142    000000 000000 0000000

ESRD   CODE-1    EFF DATE          CODE-2     EFF DATE


 PF1=INQ SCREEN    PF3/CLEAR=END                PF8=NEXT
```

itch Eligibility - APRIL 2002 [ZYA0210]

DATE 04/02/02
TIME 14 59 59

'OVIDER NAME Country Villa Nursing Rehab

OVIDER ID LTC90020G

CIPIENT ID 410405469

TE OF BIRTH 1922-10

TE OF ISSUE 94-05-01

TE OF SERVICE 02-04-02

ST RESPONSE FOR 410405469
ST NAME OVERST EVC # 477JH8M3C6 CNTY CODE 19 PRMY AID CODE 13
T SPECIAL AID CODE 80 MEDI-CAL ELIGIBLE W/ LTC SOC OF $00497 PART
B MEDICARE COVERAGE W/HIC #410405469A BILL MEDICARE COVERED SVCS
MEDICARE BEFORE MEDI-CAL OTHER HEALTH INSURANCE COVERAGE UNDER
DICARE RISK HMO CARRIER NAME UHP MEDICARE HMO ID 410405469
V OIM
******* END OF RESPONSE *********

Fac. #11
Rosemary Overstreet
#4522
3/00

COUNTRY VILLA HEALTH SERVICES

4551 Glencoe Ave , Third Floor
Marina del Rey, CA 90292
Tel (310) 574-3733
Fax (310) 574-1322 (Exec)
Fax (310) 574-1042 (Acct)
Fax (310) 574-1089 (Gen)

[ ] ORIGINAL TO FOLLOW BY MAIL
[✓] ORIGINAL WILL NOT FOLLOW

Date 7-31-02 Time 11:00 AM

SERVICES

- Comprehensive Management Services
- Regulatory Compliance
- Reimbursement Systems and Operational Management
- Corporate Compliance
- Resource Consultants
- Education and Training
- Rehabilitation Services
- Medi-Cal Subacute Programs
- Case Management
- JCAHO Accreditation
- Respiratory Therapy
- Billing and Accounts Receivable
- Medi-Cal Medicare Cost Reports
- Feasibility Studies and Market Analysis

TO	Name/Title	Anselemo
	Company	UHP
	Department	Claims dept
	Fax number	(310) 412-1288

FROM	Name/Title	Cassandra
	Company	COUNTRY VILLA HEALTH SERVICES / Nasq Rehab.
	Subject	Rosemary Overstreet Clm# 223 801

Message Attach is the claim, which was denied in error, stating medical gr responsibility, which you are going to forward back to Adj for re-processing

Number of pages transmitted including this sheet 2
(If you do not receive all the pages sent please contact us A S A P)

SERVICE INQUIRIES JOB OPPORTUNITIES
E-MAIL us at info@countryvillahealth com

The documents accompanying this telecopy transmission contain confidential information belonging to the sender that is legally privileged This information is intended only for the use of the individual or entity named above The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled unless otherwise required by state law If you are not the intended recipient you are hereby notified that any disclosure copying distribution or action taken in reliance on the contents of these documents is strictly prohibited If you receive this telecopy in error please notify the sender immediately to arrange for return of these documents

COUNTRY VILLA HLTH SRV Fax 13105741042

** Transmit Conf.Report **

Jul 31 '02 11 04

COUNTRY VILLA HLTH SRV---> 4121288	
No	0004
Mode	NORMAL
Time	1'09"
Pages	2 Page(s)
Result	O K

UHP Healthcare

Data as of 10/16/2002

Claims Forwarded To Responsible Party

COUNTRY VILLA NURSIN G &
340 SOUTH ALVARADO STREET
LOS ANGELES CA 90057

Vendor Name	Provider Name	Member Name	Member ID	Client/Claim#	Date of Service	Billed Amount	Paid Date	Forwarded To
COUNTRY VILLA NURSIN G & REH	COUNTRY VILLA NURSIN G & REH	NELSON RUBY M	210309	LV08260218203	03/26/2002	$8.46	08/27/2002	LA VIDA MEDICAL GROU F
	COUNTRY VILLA NURSIN G & REH	NELSON RUBY M	210309	LV08260218203	03/27/2002	$8.46	08/27/2002	LA VIDA MEDICAL GROU F
	COUNTRY VILLA NURSIN G & REH	NELSON RUBY M	210309	LV08260218203	03/28/2002	$8.46	08/27/2002	LA VIDA MEDICAL GROU F
	COUNTRY VILLA NURSIN G & REH	NELSON RUBY M	210309	LV08260218203	03/29/2002	$8.46	08/27/2002	LA VIDA MEDICAL GROU F
	COUNTRY VILLA NURSIN G & REH	NELSON RUBY M	210309	LV08260218203	03/30/2002	$3.23	08/27/2002	LA VIDA MEDICAL GROU F
	COUNTRY VILLA NURSIN G & REH	OVERSTREET ROSIE MAR Y	794431	LV08210215301	03/29/2002	$8.46	08/31/2002	USC UNIVERSITY AFFIL IA
	COUNTRY VILLA NURSIN G & REH	OVERSTREET ROSIE MAR Y	794431	LV08210215301	03/30/2002	$8.46	08/31/2002	USC UNIVERSITY AFFIL IA
	COUNTRY VILLA NURSIN, G & REH	OVERSTREET ROSIE MAR Y	794431	LV08210215301	03/31/2002	$8.46	08/31/2002	USC UNIVERSITY AFFIL IA
COUNTRY VILLA NURSIN G & REH				Totals	2	$48.45		

RESIDENT IDENTIFICATION

COUNTRY VILLA NURSING & REHAB

Resident Name	First Name	Resident #	Station	Room	Bed	Age
OVERSTREET	ROSIE MARY	4522-00	S3	0319	2	78

Admit Date	Admit Time	Sex	Marital Status	Birthdate
7/21/95		F	SINGLE	10/04/22

Usual Residence	County	Race	Birthplace
1760 W 36TH PLACE LOS ANGELES CA 90018	LOS ANGELES Home Phone 213-730-1331	U	

Religion	Citizenship
BAPTIST	USA CITIZEN

Responsible Party	Next of Kin	Additional Notification
OVERSTREET, ROSIE MARY 1760 W 36TH PLACE LOS ANGELES, CA 90018 Relation SELF Phone # 213 730 1331 Work Phone #	HUGHES LESTINE VIRGINIA LOS ANGELES CA 00000 Relation COUSIN Phone # 213 250 4085 Work Phone # 213 629 8545	WATSON, MARJORIE LOS ANGELES CA 00000 Relation OTHER Phone # 901 346 4771 Work Phone #

Attending Physician	Address	Phone #	Social Security Number
ZIN, AUNG	5455 WILSHIRE BLVD SUITE # 800 LOS ANGELES CA 90036	323-938-2540	410-40-5469-1

Alternate Physician	Physician Address	Phone #	Medicare Number
ON-CALL			410405469A

Dentist	Address	Phone #	
GLADKOV, ALEXANDER	6818 LA CIENEGA BLVD INGLEWOOD CA 90302	800-373-5400	

Mortuary	Address	Phone #	Other Insurance
PITCHFORD FAMILY MORTUAR	917 S LA BREA AVENUE INGLEWOOD CA 90501	310-330-7020	Insurance Number

Other Provider	Address	Phone #	Billing Status
			MEDI-CAL

Admitted From	Address	Phone #	Dates of Hospital Stay
DOHENY VILLA ST VINCENT	2131 WEST 3RD STREET LOS ANGELES CA 90057 0992	213-484-7016	7/21/95 TO 7/21/95

Other Hospitals	Phone #	Dates of Hospital Stay
		TO

Other Hospitals	Phone #	Dates of Hospital Stay
		TO

Outpatient #	Business Office #	Acute Med/Rec#	Financial Account

Admitting Diagnosis

787 2 DYSPHAGIA WITH G TUBE PLACEMEN
342 90 (L) HEMIPLEGIA
784 3 APHASIA (LOSS DIFFICULITY WIT
436 CVA
401 9 HYPERTENSION

Allergies

NO KNOWN ALLERGIES

Discharge Diagnosis

Discharge Date	Discharge Time	Discharge To

Country Villa Health Services

MEMORANDUM

TO All SNF Administrators
Business Office Managers
Business Office Consultants
Anna Farrar

FROM Rick Menchaca

RE UHP Contract

DATE January 11, 1999

Please note that we have recently renegotiated our contract with UHP Unfortunately, we have experienced a reduction from our previous rates In comparison to many of our existing managed care, the rates are still reasonable

I met with UHP's contracting department last week I was informed that their Utilization/Case Management Department is being reorganized We will have the opportunity to meet the case management staff in February

Add the enclosed fee schedule to your Managed Care Manual The new rates will apply to December claims

RM/jmr

cc Eldon Teper
Rachel Bennett
Kelly Atkins

c \data\joyce\menchaca\uhp-con 111

AMENDMENT

SKILLED NURSING FACILITY

THIS DOCUMENT, and any exhibits, attachments or schedules referred to herein, shall serve as an amendment to the Professional Services Agreement entered into on the 1st day of October 19 98, by and between the WATTSHealth Foundation, Inc , dba UHP HEALTHCARE ("UHP") and Country Villa Health Services ("SNF")

FOR AND IN CONSIDERATION of the mutual covenants hereinafter contained, the parties do hereby agree to amend their above-mentioned Professional Services Agreement as follows

1 Replace Exhibit "A" with the attached Exhibit "A"

IN WITNESS WHEREOF, the parties have caused this Amendment to be effective on this 1st day of September, 1998

WATTSHealth FOUNDATION, INC
dba UHP HEALTHCARE
("UHP")

By _____
Clyde W Oden, OD, MPH

Its President & Chief Executive Officer

Dated 11 25 98

Country Villa Health Services
("SNF")

By _____
Joel Saltzburg

Its Chief Financial Officer

Dated 11/24/1998

EXHIBIT "A"

UHP HEALTHCARE
&
COUNTRY VILLA HEALTH SERVICES
REIMBURSEMENT SCHEDULE
Effective: October 1, 1998

The following reimbursement schedule is applicable to Skilled Nursing Facilities listed in Attachment "A"

REHABILITATION LEVELS OF CARE

All levels of care include the following

- Semi-private room and meals including special diets
- House supplies - medical and pharmaceutical
- Social Services, discharge planning, multi-disciplinary team conference
- Restorative Nursing
- Laboratory Services
- Radiology Services

PATIENT SERVICES	CODES UHP Internal Codes	MEDI-CAL/ HEALTHY FAMILIES	MEDICARE/ COMMERCIAL
LEVEL I - Post Acute Medical/Surgical Services • Semi-private room • Restorative nursing care • Clinical laboratory & radiology services up to $100/month • Post surgical dressing changes • House supplies - medical & pharmaceutical	498	$135 00/per diem	$150 00/per diem
LEVEL II - Orthopedic Rehabilitation & Skilled Care *(add to the above)* • IV antibiotics and TPN (not including formula or drugs) • Insulin dependent resident and supplies • One (1) rehabilitation evaluation by (PT, OT, ST) and a maximum of 59 minutes per day, six days per week • Isolation supplies • IV hydration	497	$190 00/per diem	$250 00/per diem
LEVEL III - Orthopedic/Neurological Rehabilitation *(add to the above)* • Colostomy and ileostomy supplies and care • Enteral feeding including formula and pump • Foley catheter maintenance and irrigation • Surgical dressings and sterile supplies • Wound Care (Stage I-II decubitus • One (1) rehabilitation evaluation by the following disciplines - PT, OT, ST, RT as deemed appropriate by the Interdisciplinary Team and attending physician rehabilitation services from 60 minutes to 120 minutes per day, six days per week • Rehabilitation services include a combination of PT, OT, ST, RT as deemed appropriate by complex medical care	496	$280 00/per diem	$350 00/per diem

PATIENT SERVICES	CODES	MEDI-CAL/ HEALTHY FAMILIES	MEDICARE/ COMMERCIAL
LEVEL IV - Neurological Rehabilitation *(add to the above)* • IV and/or TPN administration (not including formula or drug) • Wound care (Stage II-IV decubitus) • Pulmonary rehabilitation for ventilator dependent patients 120 minutes of respiratory therapy per day, seven days per week • Ventilator equipment and supplies • Admission to the complex medical care unit is based upon Country Villa's admission criteria	495	$425 00/per diem	$475 00/per diem
CUSTODIAL CARE (All Inclusive) Includes routine medications (regular and special diets) *(Requires prior authorization)*	499	$90 00/per diem	N/A

EXCLUSION

The following excluded items require UHP's **COORDINATION AND PRIOR AUTHORIZATION**

SERVICES	CODES	RESPONSIBILITY
All IV medication and TPN formula, and prescription medications	260	Provided by UHP's contracted providers
All durable medical equipment ordered by a physician for the use of an individual patient, including special beds and flotation devices	274	Coordinated through UHP Case Management - only UHP contracted providers are to be used
Medical Transporation		Ambulance service use contracted providers **MedTrans (310) 851-7000 and APT (213) 299-3980** by authorization only
All services in excess of those listed above		Cost + 5%
Professional Services	99301-99313	Responsibility of Contract Medical Groups

PART B SERVICES

- Rehabilitation services in excess of limits identified in the per Diem Schedule and services rendered to UHP member eligible for Part B services only shall be reimbursed as follows

SERVICES	REV CODE	UHP INTERNAL CODE	MEDI-CAL/ HEALTHY FAMILIES	MEDICARE/ COMMERCIAL
Evaluation Physical Therapy	424	460	N/A	$80 00
Evaluation Occupational Therapy	434	460	N/A	$80 00
Evaluation Speech Therapy	444	460	N/A	$80 00
Evaluation Respiratory Therapy	410	460	N/A	$80 00
Treatment Physical Therapy	420	460	N/A	$55 00/1 hr
Treatment Occupational Therapy	430	460	N/A	$55 00/1 hr
Treatment Respiratory Therapy	410	460	N/A	$55 00/1 hr
Treatment Speech Therapy	440	460	N/A	$55 00/1 hr

NOTE Prior authorization for all Part "B" services

EXHIBIT "A"

UNITED HEALTH PLAN
&
COUNTRY VILLA SERVICES CORPORATION

Reimbursement Schedule
Effective: 6/1/92

The following reimbursement schedule is applicable to:

COUNTRY VILLA NURSING & REHABILITATION CENTER, COUNTRY VILLA PLAZA NURSING CENTER and COUNTRY VILLA SHERATON NURSING AND REHABILIATION CENTER.

REHABILITATION LEVELS OF CARE

All levels of care include the following:

Semi-private room and meals including special diets
House supplies - medical and pharmaceutical
Social services, discharge planning,
multi-disciplinary team conference
Restorative nursing
Laboratory services up to a limit of $100/mo
Radiology services up to a limit of $100/mo

	PER DIEM
LEVEL I - Orthopaedic Rehabilitation	$ 250.00
add to the above	
Insulin dependent resident and supplies 2 therapy sessions per day/six days, or 12 sessions/week including evaluation	
LEVEL II - Orthopaedic/Neurological Rehabilitation	$ 450 00
add to the above:	
Colostomy and ileostomy supplies and care Enteral feeding including formula and pump Foley catheter maintenance and irrigation Surgical dressings and sterile supplies Wound care (Stage I - II decubitus) 4 therapy sessions per day/six days, or 24 sessions/week including evaluations	

LEVEL III - Neurological Rehabilitation $ 575 00
add to the above·

IV and/or TPN administration (not including formula or drug)
Wound care (stage III - IV decubitus)
6 therapy sessions per day/6 days, or 36 sessions/week including evaluations

POST ACUTE MEDICAL/SURGICAL SERVICES $ 150 00

Semi-private room
Restorative nursing care
Clinical laboratory & radiology services up to $100/month
Isolation supplies
Post surgical dressing changes
IV and TPN administration (not including formula or drugs)
House supplies. medical & pharmaceutical

The following Reimbursement Schedule is applicable to:

COUNTRY VILLA EAST

Medical/Surgical Skilled Nursing Care $ 150 00

Per Diem rate includes.

Semi-private room and meals including special diets
Restorative nursing
House supplies - medical and pharmaceutical
Foley catheter care (maintenance and irrigation)
Insulin dependent diabetic resident and supplies
Post surgical dressing changes
Clinical laboratory services up to a limit of $100 00/month
5 therapy sessions per week including evaluations
Isolation supplies

EXCLUSIONS

The following items are excluded from the per diem schedule and shall be reimbursed at facilities' cost plus (+) ten percent (10%) Facility is to submit a vendor invoice with the claim

Prescription medications
I V and TPN formula
Respiratory therapy
Oxygen supplies and equipment

The following excluded items require UHP's coordination and prior authorization

Durable medical equipment, special beds and/or floatation devices leased for individual residents as prescribed by a physician

Transportation
Professional services

Renabilitation services in excess of limits identified in the Per Diem Schedule and services rendered to UHP members eligible for Part B services only shall be reimbursed as follows:

Physical Therapy	$ 75.00/(1) hr session
Occupational Therapy	80 00/(1) hr session
Speech Therapy	80 00/(1) hr session

NOTE:

A one and one-half percent (1 1/2%) per month penalty will be levied on payments of clean, authorized, uncontested claims not paid within 30 days of receipt of claim.

COUNTRY VILLA NURSING CTR 340 S ALVARADO ST LOS ANGELES CA 90057 213 4849730 X 0000	2	3 PATIENT CONTROL NO H4522H01 05	4 TYPE OF BILL 221

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C I D	10 L R D	11
954301174	050102	050702					

12 PATIENT NAME	13 PATIENT ADDRESS
OVERSTREET ROSIEMARY	340 S ALVARADO ST LOS ANGELES CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24	25	26	27	28	29	30	31
10041922	F	S	92801														

32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37 A B C

UNITED HEALTH PLAN
ATTENTION CLAIMS DEPT
3405 WEST IMPERIAL HIGHWAY
INGLEWOOD CA 90303
(800) 698 2016

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
270	SUPPLIES PUMP KIT	B4034	050102	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050102	1	9 79		
270	SUPPLIES PUMP KIT	B4034	050202	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050202	1	9 79		
270	SUPPLIES PUMP KIT	B4034	050302	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050302	1	9 79		
270	SUPPLIES PUMP KIT	B4034	050402	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050402	1	9 79		
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270	ENT CATEGORY 1 SYN	B4150	050502	1	9 79		
270	SUPPLIES PUMP KIT	B4034	050602	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050602	1	9 79		
270	SUPPLIES PUMP KIT	B4034	050702	1	13 34		
270	ENT CATEGORY 1 SYN	B4150	050702	1	9 79		
290	PUMP RENTAL	B9000	050102	1	4 53		
290	PUMP RENTAL	B9000	050202	1	4 53		
290	PUMP RENTAL	B9000	050302	1	4 53		
290	PUMP RENTAL	B9000	050402	1	4 53		
290	PUMP RENTAL	B9000	050502	1	4 53		
290	PUMP RENTAL	B9000	050602	1	4 53		
290	PUMP RENTAL	B9000	050702	1	4 53		
001	TOTAL				193 62		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
UHP / USC UNIV AFF	555397				193 62	

57 **DUE FROM PATIENT ▶**

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
OVERSTREET ROSIEMARY	1	410405469A		794431
OVERSTREET ROSIEMARY	1	4104054691		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
SEE MD ORDERS			

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
486	25000	7872	436	34290	4019						

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID: F23172 CHOI SEUNG HO

83 OTHER PHYS ID:

OTHER PHYS ID:

84 REMARKS: PART B OUTPATIENT SERVICES

85 PROVIDER REPRESENTATIVE: X [signature]

86 DATE: 8-4-03

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PRINT/TYPE UB 92

COUNTRY VILLA NURSING CTR 340 S ALVARADO ST LOS ANGELES CA 90057 213 4849730 X 0000	2	3 PATIENT CONTROL NO H4522H02 05	4 TYPE OF BILL 221
5 FED TAX NO 954301174	6 STATEMENT COVERS PERIOD FROM THROUGH 050802 051402	7 COV D	8 NCD / 9 CID / 10 LRD / 11

12 PATIENT NAME OVERSTREET, ROSIEMARY	13 PATIENT ADDRESS 340 S ALVARADO ST LOS ANGELES CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24 25 26 27 28 29 30	31
10041922	F	S	92801								

32 CODE / OCCURRENCE DATE	33 CODE / OCCURRENCE DATE	34 CODE / OCCURRENCE DATE	35 CODE / OCCURRENCE DATE	36 CODE / OCCURRENCE SPAN FROM THROUGH	37 A B C

UNITED HEALTH PLAN ATTENTION CLAIMS DEPT 3405 WEST IMPERIAL HIGHWAY INGLEWOOD CA 90303 (800) 698 2016	a b c d	39 CODE / VALUE CODES AMOUNT	40 CODE / VALUE CODES AMOUNT	41 CODE / VALUE CODES AMOUNT	

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	SUPPLIES PUMP KIT	B4034	050802	1	13 34		
2	270	ENT CATEGORY 1 SYN	B4150	050802	1	9 79		
3	270	SUPPLIES PUMP KIT	B4034	050902	1	13 34		
4	270	ENT CATEGORY 1 SYN	B4150	050902	1	9 79		
5	270	SUPPLIES PUMP KIT	B4034	051002	1	13 34		
6	270	ENT CATEGORY 1 SYN	B4150	051002	1	9 79		
7	270	SUPPLIES PUMP KIT	B4034	051102	1	13 34		
8	270	ENT CATEGORY 1 SYN	B4150	051102	1	9 79		
9	270	SUPPLIES PUMP KIT	B4034	051202	1	13 34		
10	270	ENT CATEGORY 1 SYN	B4150	051202	1	9 79		
11	270	SUPPLIES PUMP KIT	B4034	051302	1	13 34		
12	270	ENT CATEGORY 1 SYN	B4150	051302	1	9 79		
13	270	SUPPLIES PUMP KIT	B4034	051402	1	13 34		
14	270	ENT CATEGORY 1 SYN	B4150	051402	1	9 79		
15	290	PUMP RENTAL	B9000	050802	1	4 53		
16	290	PUMP RENTAL	B9000	050902	1	4 53		
17	290	PUMP RENTAL	B9000	051002	1	4 53		
18	290	PUMP RENTAL	B9000	051102	1	4 53		
19	290	PUMP RENTAL	B9000	051202	1	4 53		
20	290	PUMP RENTAL	B9000	051302	1	4 53		
21	290	PUMP RENTAL	B9000	051402	1	4 53		
22								
23	001	TOTAL				193 62		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
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57	DUE FROM PATIENT ▶					

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SEE MD ORDERS			

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79 PC	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS ID
F23172 CHOI SEUNG HO
83 OTHER PHYS ID
OTHER PHYS ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
PART B OUTPATIENT SERVICES	X [signature]	8-4-03

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

ST11843 1PLY UB 92

COUNTRY VILLA NURSING CTR 340 S ALVARADO ST LOS ANGELES CA 90057 213 4849730 X 0000	2	3 PATIENT CONTROL NO H4522H03 05	4 TYPE OF BILL 22

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C I D	10 L R D	11
954301174	051502	052102					

12 PATIENT NAME	13 PATIENT ADDRESS
OVERSTREET, ROSIEMARY	340 S ALVARADO ST LOS ANGELES CA 90057

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10041922	F	S	92801								

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

UNITED HEALTH PLAN
ATTENTION CLAIMS DEPT
3405 WEST IMPERIAL HIGHWAY
INGLEWOOD CA 90303
(800) 698 2016

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
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b						
c						
d						

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2	270	ENT CATEGORY 1 SYN	B4150	051502	1	9 79		
3	270	SUPPLIES PUMP KIT	B4034	051602	1	13 34		
4	270	ENT CATEGORY 1 SYN	B4150	051602	1	9 79		
5	270	SUPPLIES PUMP KIT	B4034	051702	1	13 34		
6	270	ENT CATEGORY 1 SYN	B4150	051702	1	9 79		
7	270	SUPPLIES PUMP KIT	B4034	051802	1	13 34		
8	270	ENT CATEGORY 1 SYN	B4150	051802	1	9 79		
9	270	SUPPLIES PUMP KIT	B4034	051902	1	13 34		
0	270	ENT CATEGORY 1 SYN	B4150	051902	1	9 79		
1	270	SUPPLIES PUMP KIT	B4034	052002	1	13 34		
2	270	ENT CATEGORY 1 SYN	B4150	052002	1	9 79		
3	270	SUPPLIES PUMP KIT	B4034	052102	1	13 34		
4	270	ENT CATEGORY 1 SYN	B4150	052102	1	9 79		
5	290	PUMP RENTAL	B9000	051502	1	4 53		
6	290	PUMP RENTAL	B9000	051602	1	4 53		
7	290	PUMP RENTAL	B9000	051702	1	4 53		
8	290	PUMP RENTAL	B9000	051802	1	4 53		
9	290	PUMP RENTAL	B9000	051902	1	4 53		
0	290	PUMP RENTAL	B9000	052002	1	4 53		
1	290	PUMP RENTAL	B9000	052102	1	4 53		
2								
3	001	TOTAL				193 62		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
UHP / USC UNIV AFF	555397				193 62	

57 DUE FROM PATIENT ▶

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
OVERSTREET ROSIEMARY	1	410405469A		794431
OVERSTREET ROSIEMARY	1	4104054691		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
SEE MD ORDERS			

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E CODE	78
486	25000	7870	496	34200	4019						

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID	83 OTHER PHYS ID	OTHER PHYS ID
F23172 CHOI SEUNG HO		

84 REMARKS
PART B OUTPATIENT SERVICES

85 PROVIDER REPRESENTATIVE
X [signature]

86 DATE
8-4-03

M 92L UB 92 HCFA 1450 APPROVED OMB NO 0938 0279 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

ST11843 1PLY UB

COUNTRY VILLA NURSING CTR
340 S ALVARADO ST
LOS ANGELES CA 90057
213 4849730 X 0000

3 PATIENT CONTROL NO: H4522H04 05 | TYP OF B: 22

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C I D	10 L R D	11
954301174	052202	052802					

12 PATIENT NAME	13 PATIENT ADDRESS
OVERSTREET ROSIEMARY	340 S ALVARADO ST LOS ANGELES CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24	25	26	27	28	29	30	31
10041922	F	S	92801														

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a											A
b											B
											C

38
UNITED HEALTH PLAN
ATTENTION CLAIMS DEPT
3405 WEST IMPERIAL HIGHWAY
INGLEWOOD CA 90303
(800) 698 2016

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	SUPPLIES PUMP KIT	B4034	052102	1	13 34		
2	270	ENT CATEGORY 1 SYN	B4150	052102	1	9 79		
3	270	SUPPLIES PUMP KIT	B4034	052202	1	13 34		
4	270	ENT CATEGORY 1 SYN	B4150	052202	1	9 79		
5	270	SUPPLIES PUMP KIT	B4034	052302	1	13 34		
6	270	ENT CATEGORY 1 SYN	B4150	052302	1	9 79		
7	270	SUPPLIES PUMP KIT	B4034	052402	1	13 34		
8	270	ENT CATEGORY 1 SYN	B4150	052402	1	9 79		
9	270	SUPPLIES PUMP KIT	B4034	052502	1	13 34		
10	270	ENT CATEGORY 1 SYN	B4150	052502	1	9 79		
11	270	SUPPLIES PUMP KIT	B4034	052602	1	13 34		
12	270	ENT CATEGORY 1 SYN	B4150	052602	1	9 79		
13	270	SUPPLIES PUMP KIT	B4034	052802	1	13 34		
14	270	ENT CATEGORY 1 SYN	B4150	052802	1	9 79		
15	290	PUMP RENTAL	B9000	052202	1	4 53		
16	290	PUMP RENTAL	B9000	052302	1	4 53		
17	290	PUMP RENTAL	B9000	052402	1	4 53		
18	290	PUMP RENTAL	B9000	052502	1	4 53		
19	290	PUMP RENTAL	B9000	052602	1	4 53		
20	290	PUMP RENTAL	B9000	052702	1	4 53		
21	290	PUMP RENTAL	B9000	052802	1	4 53		
22	001	TOTAL				193 62		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
UHP / USC UNIV AFF	555397				193 62	
57		DUE FROM PATIENT ▶				

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
OVERSTREET ROSIEMARY	1	410405469A		794431
OVERSTREET ROSIEMARY	1	4104054691		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
SEE MD ORDERS			

67 PRIN DIAG CD	68 CODE	69 CODE	OTHER DIAG CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
486	25000	7872	436	34290	4019						

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID: F23172 CHOI SEUNG HO
83 OTHER PHYS ID:
OTHER PHYS ID:

84 REMARKS
PART B OUTPATIENT SERVICES

85 PROVIDER REPRESENTATIVE: X Assmbla
86 DATE: 8-4-03

M 92L UB 92 HCFA 1450 APPROVED OMB NO 0938 0279 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

ST11843 1PLY UB 92

COUNTRY VILLA NURSING CTR
340 S ALVARADO ST
LOS ANGELES CA 90057
213 4849730 X 0000

2

3 PATIENT CONTROL NO: H4522H04 06

4 TYPE OF BILL: 221

5 FED TAX NO: 954301174

6 STATEMENT COVERS PERIOD: FROM 052902 THROUGH 053102

7 COV D | 8 N-C D | 9 C I D | 10 L R D | 11

12 PATIENT NAME: OVERSTREET, ROSIEMARY

13 PATIENT ADDRESS: 340 S ALVARADO ST LOS ANGELES CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	CONDITION CODES 24 25 26 27 28 29 30	31
10041922	F	S	92801								

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37
a												A
b												B
8												C

UNITED HEALTH PLAN
ATTENTION CLAIMS DEPT
3405 WEST IMPERIAL HIGHWAY
INGLEWOOD CA 90303
(800) 698 2016

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	270	SUPPLIES PUMP KIT	B4034	052902	1	13 34		
2	270	ENT CATEGORY 1 SYN	B4150	052902	1	9 79		
3	270	SUPPLIES PUMP KIT	B4034	053002	1	13 34		
4	270	ENT CATEGORY 1 SYN	B4150	053002	1	9 79		
5	270	SUPPLIES PUMP KIT	B4034	053102	1	13 34		
6	270	ENT CATEGORY 1 SYN	B4150	053102	1	9 79		
7	290	PUMP RENTAL	B9000	052902	1	4 53		
8	290	PUMP RENTAL	B9000	053002	1	4 15		
9								
0								
1								
2								
3								
4								
5								
6								
7								
8								
9								
0								
1								
2								
3								
	001	TOTAL				78 07		

50 PAYER	51 PROVIDER NO	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
OVERSTREET ROSIEMARY	555397				78 07	

57 DUE FROM PATIENT ▶

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GROUP NO
OVERSTREET ROSIEMARY	1	410405469A		794431
OVERSTREET ROSIEMARY	1	4104054691		

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
SEE MD ORDERS			

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM DIAG CD	77 E-CODE	78
486	25000	7872	496	34290	4019						

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS ID: F23172 CHOI SEUNG HO

83 OTHER PHYS ID

OTHER PHYS ID

84 REMARKS: PART B OUTPATIENT SERVICES

85 PROVIDER REPRESENTATIVE: X Cassandra

86 DATE: 8-4-03

I CERTIFY THE CERTIFICATION ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

FACILITY COUNTRY VILLA NURSING & REHAB MAY 2002 CHART COPY

PHYSICIAN'S ORDERS

DAC	ORDER #	ORDER DATE	CODE	ORDERS	ADM TIMES
				** GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	**
				********** DIET **********	
		11/13/01		RESOURCE DIABETIC PROVIDE (1210CC/1283KCALS) PER 22 HRS WITH PUMP & EQUIP, SET PUMP RATE AT 55CC/HR.	QS
				********** MEDICATION **********	
		9/28/01	G	FLUSH G- TUBE WITH 200CC H2O & FLUSH G-TUBE W/ 50CC H2O BEFORE & AFTER TUBE FEEDING ADMINSTRATION . EVERY SIX HOURS	Q6H
		9/28/01	G	CHECK & RECORD RESIDUAL AND HOLD FEEDING X1HR IF ABOVE 100CC . QSHIFT	QS
		12/31/01	I	FINGER STICK . FINGER STICK TWICE A DAY W/SLIDING SCALE COVERAGE WITH REGULAR INSULIN <150=0>151-200 =2 U">201-250=4 'U">251-300=6"U 300=8"UNITS	FSBID
		9/28/01	M	MULTIVITAMIN WITH MINERALS 5CC GASTROSTOMY TUBE DAILY	QD
		9/28/01	M	COLACE 100MG/10CC GASTROSTOMY TUBE DAILY	QD
		9/28/01	M	ASA 325 MG GASTROSTOMY TUBE DAILY FOR {CVA}	QD
		9/28/01	M	VASOTEC TABLETS 10 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS HOLD IF BP BELOW 120	Q12H
		9/28/01	M	CLONIDINE 0.2 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS (CATAPRES)	Q12H
		9/28/01	M	NITROGLYCERIN OINT 2% 1 INCH . THREE TIMES A DAY TO CHEST WALL	TID4
		2/05/02	M	DILANTIN 125 MG GASTROSTOMY TUBE TWICE DAILY	BID
		9/28/01	F	BLOOD PRESSURE . EVERY WEEK MONITOR FOR (VASOTEC)	QWK
				********** PRN MEDICATION **********	
		9/28/01	P	MOM 30CC GASTROSTOMY TUBE EVERYDAY PRN	PRN

* CONTINUED ON NEXT PAGE *

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
7/31/95	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
CHOI, SEUNG HO	213-207-5010		

DIAGNOSIS		ALLERGIES
PNEUMONIA	CVA	NO KNOWN ALLERGIES
DM	(L) HEMIPLEGIA	
DYSPHAGIA WITH G-TUBE PLA	HYPERTENSION	

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
MEDI CAL	4522-00	S3	0319	2	F	OVERSTREET ROSIE MARY	1

FACILITY COUNTRY VILLA NURSING & REHAB MAY CHART COPY

PHYSICIAN'S ORDERS

ORDER #	ORDER DATE	CODE	ORDERS	ADM TIMES
**			GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	**
			* CONTINUED - PAGE 2 *	
			FOR CONSTIPATION	
	9/28/01	P	TYLENOL 325 MGS TAB 2 GASTROSTOMY TUBE EVERY 4 HOURS PRN TEMP >100.5 DEGREES OR ABOVE CALL M.D	PRN
			********** TREATMENT **********	
	9/28/01		G- TUBE SITE: CLEANSE W/ NS COVER W/ DD DAILY	QDTX
	4/21/02		(RT)LATERAL ABDOMINAL AREA EXCORIATES CLEANSE WITH NSS APP/ LOTRIMINE POWDER X21 DAYS . DAILY	QDTX
	9/28/01		FLEETS ENEMA EVERYDAY PRN FOR SEVERE CONSTIPATION IF MOM INEFECTIVE	PRN
	9/28/01		OXYGEN AT 3 LITERS/MIN. PER NASAL CANNULA AS NEEDED FOR SOB	PRN
	9/28/01		G,TUBE 16FR/15CC CHANGE PRN FOR MALFUNCTION OR PULLED OUT . EVERYDAY PRN	PRN
			********** RESTRAINT **********	
	9/28/01		SIDE RAILS UP (2) AND LOCKED WHILE IN BED FOR SAFETY AND PROTECTION	
	9/28/01		LAP BUDDY WHEN UP IN W/C FOR SAFETY RELEASE Q2 HRS X 10 MINS FOR REPOSITION	
			********** OTHER ORDERS **********	
	9/28/01		ORAL CARE Q2HRS BY LICENSED NURSE	
	9/28/01		ACTIVITY PLAN REVIEWED AND APPROVED AND NOT IN CONFLICT WITH TREATMENT PLAN TO	
			* CONTINUED ON NEXT PAGE *	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
7/21/05	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
CHOI, SEUNG HO	213-207-5010		

DIAGNOSIS		ALLERGIES
PNEUMONIA	CVA	NO KNOWN ALLERGIES
DM	(L) HEMIPLEGIA	
DYSPHAGIA WITH G-TUBE PLA	HYPERTENSION	

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
MEDI-CAL	4522-00	S3	0319	2	F	OVERSTREET ROSIE MARY	2

FACILITY COUNTRY VILLA NURSING & REHAB MAY CHART COPY 2002

PHYSICIAN'S ORDERS

ORDER #	ORDER DATE	CODE	ORDERS	ADM TIME
			** GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED *	*
			* CONTINUED - PAGE 3 *	
			TOLERANCE QD	
	9/28/01		HEAD OF BED ELEVATED AT 30-45 DEGREES AT ALL TIMES	
	9/28/01		DILANTIN LEVEL Q MONTHLY	
	9/28/01		LUE RESTING HAND SPLINT BY	
			CNA QD X 6-8 HRS AS TOLERATED 7X WEEK	
			**********	
			** ABOVE ORDERS APPROVED FOR 45 DAYS UNLESS OTHERWISE SPECIFIED **	
			**********	
			DOCTOR SIGNATURE (WBTaylor, LVN) DATE 5/23/02	
			NURSE SIGNATURE ---------- DATE 5/23/02	
			RECAP CHECKED BY ---------- LVN DATE 04/20/02	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC
7/21/25	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
CHOI, SEUNG HO	213-207-5010		

DIAGNOSIS		ALLERGIES
PNEUMONIA	CVA	NO KNOWN ALLERGIES
DM	(L) HEMIPLEGIA	
DYSPHAGIA WITH G TUBE PLA	HYPERTENSION	

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAG
MEDI CAL	4522-00	ST	0319	2	F	OVERSTREET ROSIE MARY	2

CVCf 538 (7/99)

Printed in U

FACILITY Country Villa Nursing Rehab May 2005

PHYSICIAN'S ORDERS

CHART COPY

D/C	ORDER	ORDER DATE	CODE	ORDERS	ADM TIMES
				GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	
				MEDICATION	
				G-TUBE/NG TUBE	
		09/28/2001	M	CHECK & RECORD RESIDUAL ANDHOLD FEEDING XIHR IF ABOVE100CC QSHIFT	QS
				MEDICATION	
		09/28/2001	M	COLACE 100MG/10CC GASTROSTOMY TUBE DAILY	QD
		09/28/2001	M	ASA 325 MG GASTROSTOMY TUBE DAILY FOR (CVA)	QD
		09/28/2001	M	VASOTEC TABLETS 10 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS	[illegible]
		09/28/2001	M	CLONIDINE 0.2 MGS GASTROSTOMY TUBE EVERY TWELVE HOURS (CATAPRES)	[illegible]
		09/28/2001	M	NITROGLYCERIN OINT 2% 1 INCH THREE TIMES A DAY TO CHEST WALL	TID
		12/30/2004	M	DILANTIN 200MG(8CC) GASTROSTOMY TUBE DAILY FOR SEIZURE	QPM
		09/20/2004	M	DILANTIN 100MG(4CC) GASTROSTOMY TUBE DAILY SHAKE WELL (SEIZURES)	QD
		12/14/2004	M	MULTIVITAMIN WITH MINERALS 5CC GASTROSTOMY TUBE DAILY SUPPLEMENT	QD
		02/25/2005	M	PROSTAT 101 30ML PER G-TUBE (LOW PREALBUMIN) DAILY	QD
				VITALS	
		09/28/2001	M	BLOOD PRESSURE / EVERY THURSDAY MONITOR FOR (VASOTEC)	QDBP
				RESTRAINT	
		09/28/2001	M	SEAT BELT WHEN UP IN W/C FOR SAFETY RELEASE Q2 [illegible] MINS FOR REPOSITION INFORMED CONSENT OBTAINED BY MD QSHIFT	QS
		04/10/2005	M	BOTH SIDE RAILS UP & LOCKED WHILE IN BED FOR SAFETY & PROTECTION FROM FALLS RELEASED Q2H VERIFIED INFORMED CONSENT OBTAINED QSHIFT	QS
				NURSING INTERVENTIONS	
		10/25/2002	M	MONITOR FOR COMFORT LEVELOS (PAIN) NEG OR POSITIVE QSHIFT	QS
				********** PRN MEDICATION **********	
				PRN MEDICATION	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	L.O.C.
07/21/1995	10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE
KAHN, BRIAN	12134842044		

DIAGNOSIS		ALLERGIES
DYSPHAGIA WITH G-TUBE PLAC	HYPERTENSION	NO KNOWN ALLERGIES
CVA	APHASIA	
(L) HEMIPLEGIA	PNEUMONIA	

BILLING STATUS	PATIENT NO.	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
	000452200	S3	319	2	F	OVERSTREET ROSIE MARY	1

FACILITY Country Villa Nursing Rehab

May 2005

PHYSICIAN'S ORDERS

CHART COPY

D/C	ORDER	ORDER DATE	CODE	ORDERS	ADM TIMES
				GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	
		09/28/2001	P	MOM 30CC GASTROSTOMY TUBE EVERYDAY PRN FOR CONSTIPATION	PRN
		09/28/2001	P	TYLENOL 325 MGS TAB 2 GASTROSTOMY TUBE EVERY 4 HOURS PRN TEMP >100 5 DEGREES OR ABOVECALL M D	PRN
		04/10/2005	P	LOMOTIL 2.5MG 2 TABS GASTROSTOMY TUBE EVERY 6 HOURS PRN DIARRHEA	PRN
				********** OTHER ORDERS **********	
				OTHER ORDER	
		09/28/2001		ACTIVITY PLAN REVIEWED AND APPROVED AND NOT IN CONFLICT WITH TREATMENT PLAN TO TOLERANCE OF	
		09/28/2001		HEAD OF BED ELEVATED AT 30-45DEGREES AT ALL TIMES	
DC 5/19/05		09/28/2001		DILANTIN LEVEL Q MONTHLY	
		09/28/2001		LUE RESTING HAND SPLINT BY CNA QD X 6-8 HRS AS TOLERATED 7X WEEK	
		06/10/2004		CNA TO PERFORM PROM ON B UE/LE DURING NURSING CARE	
				********** LAB WORK **********	
				LABS	
DC 6/19		04/26/2004		DILANTIN LEVEL EVERY THREE MONTHS SEIZURE DISORDER	
				TREATMENT	
				G-TUBE/NG TUBE	
		09/28/2001		G- TUBE SITE CLEANSE W/ NS COVER W/ DD DAILY	QDTX
				PRN TREATMENTS	
		09/28/2001		FLEETS ENEMA EVERYDAY PRN FOR SEVERE CONSTIPATION IFMOM INEFECTIVE	PRN
		09/28/2001		OXYGEN AT 3 LITERS/MIN PER NASAL CANNULA AS NEEDED FOR SOB	PRN
		09/28/2001		G TUBE 16FR 7.5CC CHANGE PRN FOR MALFUNCTION OR PLUGGED EVERYDAY PRN	PRN
				********** DIET **********	

BIRTHDATE	NURSING ALERTS	LOC
07/21/1995 10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT. PHYSICIAN NAME	ALT PHYSICIAN PHONE
KAHN, BRIAN	12134842044		

DIAGNOSIS	ALLERGIES
DYSPHAGIA WITH G-TUBE PLAC CVA (L) HEMIPLEGIA HYPERTENSION APHASIA PNEUMONIA	NO KNOWN ALLERGIES

BILLING STATUS	PATIENT NO.	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
	000452200	S3	319	2	F	OVERSTREET ROSIE MARY	2

FACILITY Country Villa Nursing Rehab

May 2005

PHYSICIAN'S ORDERS

CHART COPY

D/C	ORDER	ORDER DATE	CODE	ORDERS	ADM TIMES
				GENERIC EQUIVALENT MAY BE SUBSTITUTED UNLESS OTHERWISE SPECIFIED	
				G-TUBE/NG TUBE	
		02/10/2005		PROVIDE GLYTROL (1080CC/1080CAL) 49GM PROTEIN X 18HRS SET PUMP AT 60CC PER HR ON AT 2PM OFF AT 8AM	QS
		01/10/2005		FLUSH TUBE WITH 300CC H20 Q4H TOTAL FREE H20 971CC/DAY	Q4H
**				ABOVE ORDERS APPROVED FOR 45 DAYS UNLESS OTHERWISE SPECIFIED	**

DOCTOR SIGNATURE _____ DATE ___/___/___

NURSE SIGNATURE _____ DATE ___/___/___

RECAP CHECKED BY _____ DATE ___/___/___

BIRTHDATE	NURSING ALERTS	LOC
07/21/1995 10/04/1922		8

PHYSICIAN NAME	PHYSICIAN PHONE	ALT. PHYSICIAN NAME	ALT. PHYSICIAN PHONE
KAHN, BRIAN	12134842044		

DIAGNOSIS		ALLERGIES
DYSPHAGIA WITH G-TUBE PLAC	HYPERTENSION	NO KNOWN ALLERGIES
CVA	APHASIA	
(L) HEMIPLEGIA	PNEUMONIA	

BILLING STATUS	PATIENT NO.	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
	000452200	S3	319	2	F	OVERSTREET ROSIE MARY	3

FACILITY CVRC

Family Name	First Name	Attending Physician	Room No	Admission No
Overstreet, Rosemary		Dr. Choi	319 B	

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis
5/19/05 8:00am		> DC previous order for seat belt when in w/c	
		> Self release belt while up in wheelchair	
		For safety 2° poor safety awareness R/T dementia. Release - 2"x10mm For reorientation Informed consent obtained by MD	

Signature of Nurse Receiving Order: Sofia Date:

Signature of Physician: per MD Dr. Choi Date:

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet

Res Care Plan: Communicated

PHYSICIAN'S TELEPHONE ORDERS

FACILITY

Family Name	First Name	Attending Physician	Room No	Admission No

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis

Signature of Nurse Receiving Order: Signature of Physician: Date:

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet

Res Care Plan: Communicated

PHYSICIAN'S TELEPHONE ORDERS

FACILITY

Family Name	First Name	Attending Physician	Room No	Admission No

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis

Signature of Nurse Receiving Order: Signature of Physician: Date:

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet

Res Care Plan: Communicated

PHYSICIAN'S TELEPHONE ORDERS

FACILITY

CHART COPY

PHYSICIAN'S ORDERS

DC DATE	ORDER DATE	CODE	ORDERS	ADM TIMES
	5/17/05		May Recap 2005 > Dilantin level Q 3 months Dx-seizure disorder	

ADMIT DATE	BIRTHDATE	NURSING ALERTS	LOC	ALT

PHYSICIAN NAME	PHYSICIAN PHONE	ALT PHYSICIAN NAME	ALT PHYSICIAN PHONE

DIAGNOSIS	ALLERGIES

BILLING STATUS	PATIENT NO	STA	ROOM	BED	SEX	PATIENT NAME	PAGE
	452200	3	319	B		OVERSTREET ROSIE MARY	

FACILITY CVR Ohab

Family Name	First Name	Attending Physician	Room No	Admission No
Overstreet, Rosiemary		Dr. Choi	319B	

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis
4/29/05	<	Amoxicillin 500mg via GT Q8° x 1wk	
230pm			> productive
	<	Robitussin 10cc via GT PRN cough	cough
Noted			
		T/Dr Choi / J Molina LVN	

Signature of Nurse Receiving Order	Signature of Physician	Date
J Molina LVN		

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects		Res. Care Plan
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet		Communicated

PHYSICIAN'S TELEPHONE ORDERS

51369

FACILITY CVRC

Family Name	First Name	Attending Physician	Room No	Admission No
Overstreet,	Rosemary	Dr Choi	319B	

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis
5/9/05		> ok to follow dietary recommendations	
1245pm	Noted	CBC, CMP	
	1245p		
		T.O / Dr Choi / VBrad	

Signature of Nurse Receiving Order	Signature of Physician	Date
VBrad LVN		

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects		Res. Care Plan
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet		Communicated

PHYSICIAN'S TELEPHONE ORDERS

FACILITY CVRC

Family Name	First Name	Attending Physician	Room No	Admission No
Overstreet,	Rosemary	Dr. Choi	319B	

Date/Time Ordered	Date Discontinued	ORDERS	Diagnosis
		> Dilantin level q 3 mth	
7/19/05		> DC previous dilantin level orders	
Noted			

Signature of Nurse Receiving Order	Signature of Physician	Date

	On MD Order Sheet		Med/Tx Sheet		Resident informed drug effects / side effects		Res Care Plan
	Pharmacy		Nurses Notes		And Documented in Nsg Notes / Med Sheet		Communicated

PHYSICIAN'S TELEPHONE ORDERS

From 05/01/2005 to 05/31/2005

MEDICATION RECORD

FACILITY Country Villa Nursing Rehab

MEDICATION CHART RECORD	HOUR
09/28/2001 CHECK & RECORD RESIDUAL ANDHOLD FEEDING X1HR IF ABOVE100CC QSHIFT	11-7 7-3 3-11
09/28/2001 COLACE 100MG/10CC DAILY GASTROSTOMY TUBE	06 00A
09/28/2001 ASA 325 MG DAILY GASTROSTOMY TUBE FOR {CVA}	06 00A
09/28/2001 VASOTEC TABLETS 10 MGS EVERY TWELVE HOURS GASTROSTOMY TUBE	06 00 06 00P
09/28/2001 CLONIDINE 0 2 MGS EVERY TWELVE HOURS GASTROSTOMY TUBE (CATAPRES)	06 00 06 00P
09/28/2001 NITROGLYCERIN OINT 2% 1 INCH THREE TIMES A DAY TO CHEST WALL	06 00 13 00 17 00
12/30/2004 DILANTIN 200MG(8CC) DAILY GASTROSTOMY TUBE FOR SEIZURE	17 00
09/20/2004 DILANTIN 100MG(4CC) DAILY GASTROSTOMY TUBE SHAKE WELL (SEIZURES)	06 00A

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT
C Usalde LVN	CU						

DIAGNOSIS: 787 2 DYSPHAGIA WITH G-TUBE PLACEMENT; 342 90 (L) HEMIPLEGIA; 436 CVA; 401 9 HYPERTENSION

ALLERGIES: NO KNOWN ALLERGIES

DATE: 04/25/2005

RESIDENT: OVERSTREET ROSIE MARY

NO.	ROOM	BED	REQ PHYS	KAHN, BRIAN
452200	319	2	ATT PHYS	

PHYS PHONE: 1 (213) 484-2044

PHYS PHONE:

From 05/01/2005 to 05/31/2005

MEDICATION RECORD

FACILITY Country Villa Nursing Rehab

MEDICATION CHART RECORD	HOUR	2	4	6	8	10	12	14	16	18	20	22	24	26	28	30
12/14/2004 MULTIVITAMIN WITH MINERALS 5CC DAILY GASTROSTOMY TUBE SUPPLEMENT	06 00A															
02/25/2005 PROSTAT 101 30ML PER G-TUBE (LOW PREALBUMIN) DAILY	06 00A															
09/28/2001 BLOOD PRESSURE EVERY THURSDAY MONITOR FOR (VASOTEC)	7 3 B/P X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	10	X X X	X X X
09/28/2001 SEAT BELT WHEN UP IN W/C FOR SAFETY RELEASE Q2 HRS X 10 MINS FOR REPOSITION INFORMED CONSENT OBTAINED BY	11-7 7-3 3-11															
(continued) MD QSHIFT																
04/10/2005 BOTH SIDE RAILS UP & LOCKED WHILE IN BED FOR SAFETY & PROTECTION FROM FALLS RELEASED Q2H VERIFIED INFORMED	11-7 7-3 3 11															
(continued) CONSENT OBTAINED QSHIFT																
10/25/2002 MONITOR FOR COMFORT LEVELQS (PAIN) NEG OR POSITIVE QSHIFT	11-7 7-3 3-11															

NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT
C. Ubaldo LVN	VB CU						

DIAGNOSIS

DATE 04/25/2005

RESIDENT OVERSTREET ROSIE MARY

NO	ROOM	BED
452200	319	2

REC PHYS KAHN BRIAN

ALL PHYS

PHONE 1 (213) 484-2044

PHONE

From 05/01/2005 to 05/31/2005

MEDICATION RECORD

FACILITY Country Villa Nursing Rehab

MEDICATION CHART RECORD	HOUR
02/10/2005 PROVIDE GLYTROL (1080CC/1080CAL) 49GM PROTEIN X 18HRS SET PUMP AT 60CC PER HR ON AT 2PM OFF AT 8AM	8-00 AM OFF 2PM ON
01/10/2005 FLUSH TUBE WITH 300CC H20 Q4H TOTAL FREE H20 2718CC/DAY	09 00A 1 00PM 5 00PM 9 00PM
* cont from above	1 00AM 5 00AM
Amoxicillin 500 mg via GT Q8° x 7 day for cough	6AM 2pm 10pm

Days: 1–31 (daily nurse initials, handwritten; [illegible])

NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT
[illegible]	VB						
C Ubalde LVN	CU						

DIAGNOSIS

ALLERGIES

DATE 04/25/2005

RESIDENT OVERSTREET ROSIE MARY

No.	ROOM	BED	ATTENDING PHYS	ALT PHYS	PHYS PHONE
452200	319	2	KAHN BRIAN		1 (213) 484-2044

From 05/01/20[illegible] to 05/31/2005

PRN MEDICATION RECORD

FACILITY Country Villa Nursing Rehab

PRN MEDICATION CHART RECOR	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
09/28/2001 MOM 30CC EVERYDAY PRN GASTROSTOMY TUBE FOR CONSTIPATION	PRN																															
09/28/2001 TYLENOL 325 MGS TAB 2 EVERY 4 HOURS PRN GASTROSTOMY TUBE TEMP >100 5 DEGREES OR ABOVECALL M D	PRN																															
04/10/2005 LOMOTIL 2 5MG 2 TABS EVERY 6 HOURS PRN GASTROSTOMY TUBE DIARRHEA	PRN																															

NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT	NURSE S SIGNATURE	INIT

DIAGNOSIS: 787 2 DYSPHAGIA WITH G-TUBE PLACEMENT; 342 90 (L) HEMIPLEGIA
436 CVA; 401 9 HYPERTENSION

ALLERGIES: NO KNOWN ALLERGIES

DATE: 04/25/2005

RESIDENT: OVERSTREET ROSIE MARY

NO: 452200 | ROOM: 319 | BED: 2 | REG PHYS: KAHN BRIAN | PHYS PHONE: 1 (213) 484-2044 | EMERG PHONE:

PAGE: 1

From 05/01/2005 to 05/31/2005

TREATMENT RECORD

FACILITY Country Villa Nursing Rehab

TREATMENT RECORD	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
09/28/2001 G- TUBE SITE CLEANSE W/ NS COVER W/ DD DAILY	7 3	m	m	m	[illegible]	[illegible]	[illegible]	cu	cu	m	m	[illegible]	[illegible]	m	cu	m	m	m	[illegible]	[illegible]	m	cu	cu	m	m	[illegible]	[illegible]	m	m	m	m	m
09/28/2001 FLEETS ENEMA FOR SEVERE CONSTIPATION IFMOM INEFECTIVE EVERYDAY PRN	PRN																															
09/28/2001 OXYGEN AT 3 LITERS/MIN FOR SOB PER NASAL CANNULA AS NEEDED	PRN																															
09/28/2001 G TUBE 16FR/15CC CHANGE PRN FOR MALFUNCTION OR PULLED OUT EVERYDAY PRN	PRN																															

NURSE S SIGNATURE: t Ubalde LVN INIT: cu

NURSE S SIGNATURE INIT

NURSE S SIGNATURE: [illegible] LVN INIT: [illegible]

NURSE S SIGNATURE INIT

DIAGNOSIS 787 2 DYSPHAGIA WITH G TUBE PLACEMENT 342 90 (L) HEMIPLEGIA
436 CVA 401 9 HYPERTENSION

ALLERGIES NO KNOWN ALLERGIES

DATE 04/25/2005

PESIDENT OVERSTREET ROSIE MARY

NO	ROOM	BED	REG PHYS	KAHN BRIAN
452200	319	2	ALT PHYS	

PHYS PHONE 1 (213) 484 2044

PHYS PHONE

PAGE 1

PROGRESS NOTES MUST REFLECT THE FOLLOWING

1 Response to his environment
2 Physical limitations
3 Independent activities
4 Dependency status
5 Behavior Changes
6 Skin problems
7 Dietary problems
8 Restorative measures

DATE	LICENSED PERSONNEL WEEKLY PROGRESS NOTES
5-3-5 9:35P	VS - 97.9 118/60 76 18 Asleep in bed Alert and responsive to tactile stimuli GT feed well tolerated No SOB. Continue ATB of amoxicillin for Tx of productive cough Periods of coughing noted No ASE No % pain or discomfort Will continue to monitor. —— W. Y.
5/4/05 7 AM	V/S 136/74 97.8 76 20 Resident in bed asleep. Respirations even & unlabored On GTF of glytrol @ 60 cc/hr, intact flushed c̄ H_2O Still on ATB & ASE noted No episodes of coughing during the shift Side rails up & locked for safety, HOB elevated. Kept dry & comfortable —— Bry, LVN
5/4/05 10pm	V/S 116/74 98.8 72 18 0/10 On GTF, tolerating well, NO NIV noted. On Atb via GT for cough NO ASE noted Incont B+B. kept clean and dry Call light within reach, needs are attended —— [illegible] RN
5/5/4 2AM	BP 120/60 T 98.8 R 20 P 74.. Resident asleep - GT patent incont GTF tolerated well c̄ no residual noted Still on ATB via GT for cough c̄ no ASE such as GT report or pain passes. fluids flushed via GT as ordered. continued to monitor —— [illegible]
5/5/05 1130am	VS 130/70 78 20 98.1 Resident up in wheelchair Alert & responsive to tactile stimuli. Cont on ATB therapy for cough. ∅ ASE noted GT intact & infusing well Will cont to monitor —— [illegible] LVN
5/6/05 7AM	V/S 134/72 98.2 70 20. Resident in bed, asleep Respirations unlabored On GTF of glytrol @ 60 cc/hr. GT site intact & flushed c̄ H_2O. On ATB ∅ ASE noted No coughing noted during the shift HOB elevated, side rails up & locked Kept dry & comfortable —— Bry, LVN
5/6/05 11am	VS 137/72 62 20 97.6 —— Resident up in W/C Alert & responsive to tactile stimuli Cont on ATB therapy for cough ∅ ASE noted GT patent & infusing well fluids flushed via GT & tolerated well. will cont to monitor —— [illegible]
5/6/05 11pm	V/S 120/74 98.6 77 20 0/10 Alert, oriented, non warmed not able to make needs known On GTF, tolerating well NON noted on Atb - ∅ ASE noted kept clean and dry. [illegible]

NAME LAST	FIRST	MIDDLE	ROOM NO	ATTENDING PHYSICIAN	HOSP NO
OVERSTEER	Rosemary		319B	CH01	

CVNf 528 (7/99)

LICENSED PERSONNEL WEEKLY PROGRESS NOTES

PROGRESS NOTES MUST REFLECT THE FOLLOWING

1 Response to his environment
2 Physical limitations
3 Independent activities
4 Dependency status
5 Behavior Changes
6 Skin problems
7 Dietary problems
8 Restorative measures

DATE	LICENSED PERSONNEL WEEKLY PROGRESS NOTES
5/9/05	spoke to Dr Choi & new orders given per MD to follow dietary recommendati
245pm	for CBC, CMP 2° ATB therapy completed — [signature]
5/10/05	paged Dr Choi & received call back re labs done 5/10/05 & new orde
950pm	given @ this time — [signature]
5/19/05	seen by MD c̄ Dilantin level Q3 months & seat belt
850am	while in w/c orders clarified orders carried out
	and endorsed — [signature]

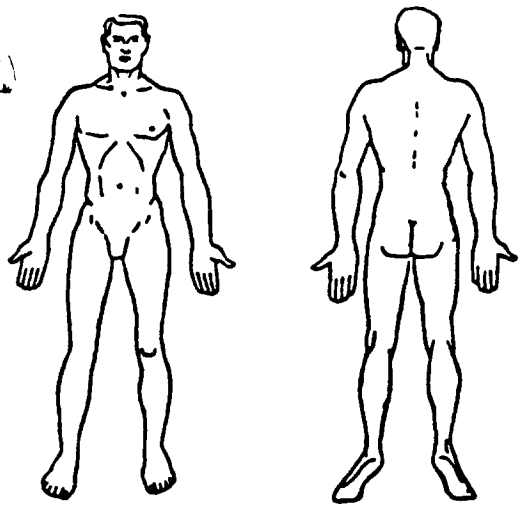
NAME - LAST	FIRST	MIDDLE	ROOM NO	ATTENDING PHYSICIAN	HOSP NO
Overstreet	Rosemary		319B	Choi	

CVNf 528 (7/99)

LICENSED PERSONNEL WEEKLY PROGRESS NOTES

LICENSED NURSE WEEKLY SUMMARY

Date 5/4/05



1) SKIN ASSESSMENT

No new skin tear noted

CURRENT TREATMENTS & SUMMARY OF EFFECTIVENESS

Wound Management Prevention Measures *(circle)*

Positioning Pillows	Alternating Pressure
Floatation	Air Fluidization
Heel Protectors	Elbow Protector

2) VITAL SIGNS TEMP 98.8 PULSE 72 RESP 18 BP 116/74 PAIN RATING 0/10

3) NUTRITION/HYDRATION Average % of meal intake past week _____ Nourishment _____

Enteral Feedings (formula type & calories/day/H_2O Flush) _____

Assistive Device Used for Eating Glytrol @ 60 cc/hr. Fluid Restriction Yes (No)

Dehydration Risk Factors Present & Addressed In Plan Of Care (i e diuretics, difficulty grasping cup, swallowing deficit)

No S/S of dehydration noted

Recent weight loss or trend _____ Overall assessment of nutrition/hydration _____

04-05-05 140 lbs 03-05-05 141 lb

4) RESTORATIVE MEASURES & PROGRESS/EFFECTIVENESS (ROM, feeding program, bowel/bladder retraining, etc)

CNA to perform PROM on BUE/LE while giving Nsg care

5) BOWEL/BLADDER (continence, UTI's, constipation, foley cath, suprapubic, etc) _____

Incont B & B no UTI, NO Constipation noted

6) PSYCHOSOCIAL ISSUES (socialization, mood or behavior problems, family support, etc) _____

No change in mood noted

NAME	PHYSICIAN	ROOM #	RECORD
CV, Robert Rosemary	Chen	319 B	

LICENSED NURSE WEEKLY SUMMARY

7) PSYCHOTROPHIC MEDS (medication effectiveness adverse reactions) N/A

Other non-medicinal approaches used to modify behavior explain procedures prior to performing.

Last attempted dose reduction & results Ø

8) PHYSICAL RESTRAINTS (type used, when used, effectiveness, adverse reactions) bed side rails up

Date of last attempted reduction & results Ø

Devices used for positioning or to aide in increasing self-performance of functional mobility pillows

Side rails used for ☐ ~~Safety~~ ☐ Enabler for turning

9) FALLS IN THE LAST WEEK & OUTCOME/PREVENTION Ø

History of falls ☐ Yes ☐ ~~No~~

☑ ~~Is~~ ☐ Is not at risk for falls If yes, is it on PCP?

10) Functional Status / ADL Skills

TRANSFERS	total assists
LOCOMOTION	
BED MOBILITY	
BATHING	
DRESSING	
GROOMING/HYGIENE	
EATING	– GTF
TOILET USE	– incontinent of B + B.

11) Physical Condition (note any changes in condition during the past week, i e skin tears, antibiotic/medication changes,edema,temperature elevation, need for O_2, increased lethargy, IV's, suctioning, diabetic monitoring) no significant change noted.

12) SUMMARY OF RESIDENT'S PROGRESS OR LACK OF PROGRESS TOWARDS GOALS / EXPECTED OUTCOMES ADDRESSED IN INDIVIDUAL PLAN OF CARE continue plan of care

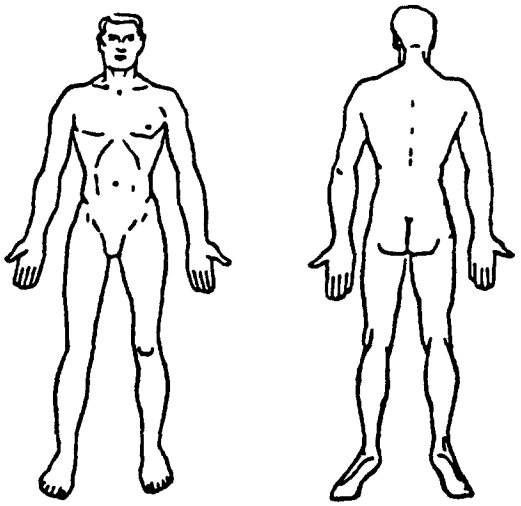
SIGNATURE Bonny, LVN

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet, Rosemary	Cher	319 B	

CVNf 527

LICENSED NURSE WEEKLY SUMMARY

Date 5/11/05



1) SKIN ASSESSMENT No new skin breakdown noted

CURRENT TREATMENTS & SUMMARY OF EFFECTIVENESS Ø

Wound Management Prevention Measures *(circle)*

Positioning Pillows	Alternating Pressure
Floatation	Air Fluidization
Heel Protectors	Elbow Protector

2) VITAL SIGNS TEMP 97.8 PULSE 68 RESP 20 BP 156/76 PAIN RATING 0/10

3) NUTRITION/HYDRATION Average % of meal intake past week Ø Nourishment Ø

Enteral Feedings (formula type & calories/day/H_2O Flush) glytrol (1080 cc / 1080 cal) @ 60 cc/hr

Assistive Device Used for Eating Ø Fluid Restriction Yes (No)

Dehydration Risk Factors Present & Addressed In Plan Of Care (i e diuretics, difficulty grasping cup, swallowing deficit)

no signs & symptoms of dehydration noted

Recent weight loss or trend -2 lbs Overall assessment of nutrition/hydration

previous wt 140 lbs (4/5/05)

present wt 138 lbs (5/5/05)

4) RESTORATIVE MEASURES & PROGRESS/EFFECTIVENESS (ROM, feeding program, bowel/bladder retraining, etc)

CNA to perform PROM on (B) U & LE while giving nsg. care

5) BOWEL/BLADDER (continence, UTI's, constipation, foley cath, suprapubic, etc)

incontinent of B & B, Ø signs of UTI, Ø constipation

6) PSYCHOSOCIAL ISSUES (socialization, mood or behavior problems, family support, etc)

no mood or behavioral problems noted.

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet, Rosie Mary	Choi	319 B	

LICENSED NURSE WEEKLY SUMMARY

7) PSYCHOTROPHIC MEDS (medication, effectiveness, adverse reactions) NA

Other non-medicinal approaches used to modify behavior

Explain all procedures prior to performing.

Last attempted dose reduction & results 0

8) PHYSICAL RESTRAINTS (type used, when used, effectiveness, adverse reactions)

BSR ↑ ↑ locked for safety.

Date of last attempted reduction & results 0

Devices used for positioning or to aide in increasing self-performance of functional mobility

pillows

Side rails used for ☒ Safety ☐ Enabler for turning

9) FALLS IN THE LAST WEEK & OUTCOME/PREVENTION 0

History of falls ☐ Yes ☒ No

☒ Is ☐ Is not at risk for falls If yes, is it on PCP?

10) Functional Status / ADL Skills

TRANSFERS	total assist
LOCOMOTION	
BED MOBILITY	
BATHING	
DRESSING	
GROOMING/HYGIENE	
EATING	G/T
TOILET USE	incontinent of B/B

11) Physical Condition (note any changes in condition during the past week, i e skin tears, antibiotic/medication changes,edema,temperature elevation, need for O_2, increased lethargy, IV's, suctioning, diabetic monitoring)

No significant changes noted

12) SUMMARY OF RESIDENT'S PROGRESS OR LACK OF PROGRESS TOWARDS GOALS / EXPECTED OUTCOMES ADDRESSED IN INDIVIDUAL PLAN OF CARE

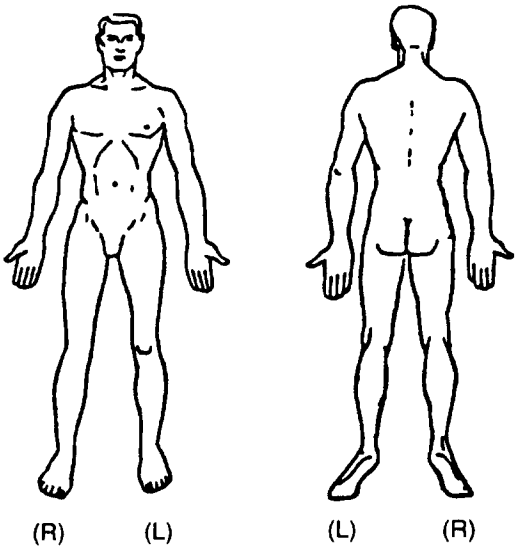
Continue plan of care

SIGNATURE JMcKinnaLVN

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet, Rosemary		Chel 319B	

LICENSED NURSE WEEKLY SUMMARY

Date 5/18/05
7-3



1) SKIN ASSESSMENT

No new skin breakdown noted

CURRENT TREATMENTS & SUMMARY OF EFFECTIVENESS

Wound Management Prevention Measures *(circle)*

(Positioning Pillows)	Alternating Pressure
Floatation	Air Fluidization
Heel Protectors	Elbow Protector

2) VITAL SIGNS TEMP 98.4 PULSE 70 RESP 18 BP 144/70 PAIN RATING 0/10

3) NUTRITION/HYDRATION Average % of meal intake past week NA Nourishment NA

Enteral Feedings (formula type & calories/day/H_2O Flush) glytrol (1080 cc / 1080 cal) @ 60 cc/hr

Assistive Device Used for Eating GTF Fluid Restriction Yes (No)

Dehydration Risk Factors Present & Addressed In Plan Of Care (i e diuretics, difficulty grasping cup, swallowing deficit)

↑ S/S of dehydration noted

Recent weight loss or trend ↓ 2 lbs Overall assessment of nutrition/hydration

previous WT 141 lbs 4/15/05
current WT 138 lbs 05/05/05

4) RESTORATIVE MEASURES & PROGRESS/EFFECTIVENESS (ROM, feeding program, bowel/bladder retraining, etc)

CNA to perform PROM on (B) U & LE while giving Nursing Care

5) BOWEL/BLADDER (continence, UTI's, constipation, foley cath, suprapubic, etc)

Incontinent of B/B ↑ signs of UTI / Constipation

6) PSYCHOSOCIAL ISSUES (socialization, mood or behavior problems, family support, etc)

↑ mood or behavioral changes noted

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet, Rosie Mary	dbd	319B	

LICENSED NURSE WEEKLY SUMMARY

7) PSYCHOTROPHIC MEDS (medication, effectiveness adverse reactions) N/A

Other non-medicinal approaches used to modify behavior 0

Last attempted dose reduction & results 0

8) PHYSICAL RESTRAINTS (type used, when used effectiveness, adverse reactions)

↑ BSR + locked

Date of last attempted reduction & results

Devices used for positioning or to aide in increasing self-performance of functional mobility

Side rails used for ☒ Safety ☐ Enabler for turning

9) FALLS IN THE LAST WEEK & OUTCOME/PREVENTION

History of falls ☐ Yes ☒ No

☒ Is ☐ Is not at risk for falls If yes, is it on PCP?

10) Functional Status / ADL Skills

TRANSFERS	
LOCOMOTION	
BED MOBILITY	Total assist
BATHING	
DRESSING	
GROOMING/HYGIENE	
EATING	
TOILET USE	

11) Physical Condition (note any changes in condition during the past week, i e skin tears, antibiotic/medication changes,edema,temperature elevation, need for O_2, increased lethargy, IV's, suctioning, diabetic monitoring)

No significant change noted

12) SUMMARY OF RESIDENT'S PROGRESS OR LACK OF PROGRESS TOWARDS GOALS / EXPECTED OUTCOMES ADDRESSED IN INDIVIDUAL PLAN OF CARE

will cont care of plan

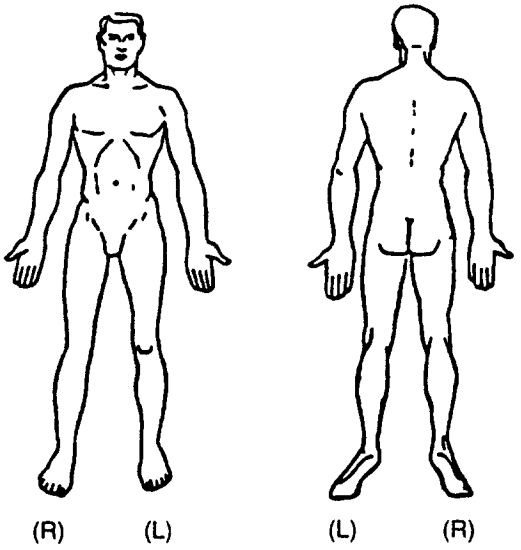
SIGNATURE 5/2 [signature] RN

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet Rosemary	Dr Choi	319B	

CVNf 527

LICENSED NURSE WEEKLY SUMMARY

Date 5/25/05



(R) (L) (L) (R)

1) SKIN ASSESSMENT

Ø new skin problem noted

CURRENT TREATMENTS & SUMMARY OF EFFECTIVENESS

Wound Management Prevention Measures *(circle)*

Positioning Pillows	Alternating Pressure
Floatation	Air Fluidization
Heel Protectors	Elbow Protector

2) VITAL SIGNS TEMP 96.8 PULSE 80 RESP 18 BP 1K/60 PAIN RATING 0/10

3) NUTRITION/HYDRATION Average % of meal intake past week Ø Nourishment Ø

Enteral Feedings (formula type & calories/day/H_2O Flush) Glytrol @ 60 cc/hr X 18 hrs + 300 cc H2O @ 6°

Assistive Device Used for Eating _____ Fluid Restriction Yes No

Dehydration Risk Factors Present & Addressed In Plan Of Care (i e diuretics difficulty grasping cup, swallowing deficit)

No S/S of dehydration noted

Recent weight loss or trend _____ Overall assessment of nutrition/hydration _____

05/05/05 138 lbs 04/05/05 140 lbs

4) RESTORATIVE MEASURES & PROGRESS/EFFECTIVENESS (ROM, feeding program, bowel/bladder retraining, etc)

CNA to perform PROM on B UE/LE while giving resp care

5) BOWEL/BLADDER (continence, UTI's, constipation, foley cath, suprapubic, etc)

Incent of B/B Ø UTI, Ø Constipation

6) PSYCHOSOCIAL ISSUES (socialization, mood or behavior problems, family support, etc)

No change in mood noted

NAME	PHYSICIAN	ROOM #	RECORD
Oversteet Rosemary	Dr Chot	319B	

CVNf-527 (Rev 10/00) SNF Forms (800) 648 6499

LICENSED NURSE WEEKLY SUMMARY

7) PSYCHOTROPHIC MEDS (medication, effectiveness adverse reactions) N/A

Other non-medicinal approaches used to modify behavior

explain procedure before performing it to reward

Last attempted dose reduction & results

8) PHYSICAL RESTRAINTS (type used, when used effectiveness adverse reactions)

↑ BSR + locked

Date of last attempted reduction & results 0

Devices used for positioning or to aide in increasing self-performance of functional mobility

Side rails used for ☒ Safety ☐ Enabler for turning

9) FALLS IN THE LAST WEEK & OUTCOME/PREVENTION

History of falls ☐ Yes ☒ No

☒ Is ☐ Is not at risk for falls If yes, is it on PCP?

10) Functional Status / ADL Skills

TRANSFERS	
LOCOMOTION	
BED MOBILITY	
BATHING	Total Assist
DRESSING	
GROOMING/HYGIENE	
EATING	
TOILET USE	

11) Physical Condition (note any changes in condition during the past week, i e skin tears, antibiotic/medication changes,edema,temperature elevation, need for O_2, increased lethargy, IV's, suctioning, diabetic monitoring)

On Ath for Cough

12) SUMMARY OF RESIDENT'S PROGRESS OR LACK OF PROGRESS TOWARDS GOALS / EXPECTED OUTCOMES ADDRESSED IN INDIVIDUAL PLAN OF CARE

Will Cont Care of plan

SIGNATURE [signature]

NAME	PHYSICIAN	ROOM #	RECORD
Overstreet Rosemary	Choi	319B	

CVNf-527

RESIDENT IDENTIFICATION
COUNTRY VILLA NURSING & REHAB

Resident Name	First Name	Resident #	Station Room Bed	Age
OVERSTREET	ROSIE MARY	4522-00	S3 0319-2	82

Admit Date	Admit Time	Sex	Marital Status	Birthdate
07/21/1995		F	SINGLE	10/04/1922

Usual Residence	County	Race	Birthplace
1760 W 36TH PLACE LOS ANGELES, CA 90018	LOS ANGELES **Home Phone** 1-213-730-1331	U	MEMPHIS TENNESSEE,
		Religion BAPTIST	**Citizenship** USA CITIZEN

Responsible Party	Next of Kin	Additional Notify
HUGHES, VIRGINIA **Relation** COUSIN LOS ANGELES, CA 00000 **Phone** 0-323-750-4085 **Work Phone**	WATSON, MARJORIE **Relation** OTHER LOS ANGELES, CA 00000 **Phone** 1-901-346-4771 **Work Phone**	**Work Phone**

Attending Physician	Address	Phone	Social Security #
CHOI,SEUNG HO	1711 WEST TEMPLE STREET LOS ANGELES, CA 90026	1-213-207-5010	410-40-5469
Alternate Physician ON-CALL	**Address** , 00000	**Phone**	**Medicare Number** 410405469A
Dentist GLADKOV, ALEXANDER	**Address** 6818 LA CIENEGA BLVD INGLEWOOD, CA 90302	**Phone** 1-800-373-5400	
Mortuary ARMSTRONG MORTUARY CREMATION	**Address** 931 VENICE BLVD LOS ANGELES, CA 90015	**Phone** 1-213-747-9121	**Other Insurance** **Insurance #** 410405469A
Other Provider	**Address**	**Phone**	**Billing Status** -410405469A
Admitted From SAINT VINCENT'S MEDICAL CENTER	**Address** 2131 WEST 3RD STREET LOS ANGELES, CA 90057-0992	**Phone** 1-213-484-7111	**Dates of Hospital Stay** 09/25/2001 TO 09/28/2001
Other Hospitals DOHENY VILLA- ST VINCENT		**Phone** 1-213-484-7016	**Dates of Hospital Stay** 07/21/1995 TO 07/21/1995
Other Hospitals		**Phone**	**Dates of Hospital Stay**

Outpatient #	Business Office #	Acute Med/Rec#	Financial Acct

ADMITTING DIAGNOSIS

787 2-DYSPHAGIA WITH G-TUBE PL
342 90-(L) HEMIPLEGIA
784 3-APHASIA
250 00-DM
436 -CVA
401 9-HYPERTENSION
486 -PNEUMONIA

ALLERGIES

NO KNOWN ALLERGIES

DISCHARGE DIAGNOSIS

Discharge Date	Discharge Time	Discharge To

APPROVED OMB NO 0938

COUNTRY VILLA NURSING CTR
340 S ALVARADO ST
LOS ANGELES CA 90057
213-4849730 X-0000

3 PATIENT CONTROL NO: A6697-01-07

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C-I D	10 L R D	11
954301174	070100	073100	31		31		

12 PATIENT NAME: FLOYD, ETHEL

13 PATIENT ADDRESS: 4606 S FIGUEROA LOS ANGELES CA 9003

14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24	25	26	27	28	29	30	31
02111928	F	S	060600		1	1		30									

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
								70	50300	51600	A B C

38 UHP HEALTHCARE
ATTENTION CLAIMS
1405 WEST IMPERIAL HIGHWAY
INGLEWOOD CA 90303-0000
(800) 544-0088

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
09	3007 00				

42 REV CD	43 DESCRIPTION	44 HCPCS RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM AND BOARD	145 00		31	8220 40		
0250	PHARMACY				795 06		
0258	I V ADDITIVES/SUPPLIES				1598 24		
0270	MED/SURGICAL SUPPLIES				400 46		
0300	LABORATORY				2346 40		
0320	RADIOLOGY-DX				306 45		
0412	OXYGEN SUPPLIES				54 84		
0420	PHYSICAL THERAPY SUPPLY				2750 00		
	Medicare primary Please pay co-pay amount of $ 3007 00						
0001	TOTAL				16471 85		

50 PAYER	51 PROVIDER	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
MEDICARE UHP	555397	Y	Y		3007 00	

57 DUE FROM PATIENT

58 INSURED'S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GORUP NO
FLOYD, ETHEL Floyd, Ethel	01	419506021A 419-50-6021		402702

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	OTHER DIAG CODES 71 CODE	72 CODE	73 CODE	74 CODE	75	76
7851	4280	25001	3481	0389					

79 PC	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS ID
					[illegible]

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS ID

84 REMARKS

B — 92 | 81

APPROVED OMB NO 0938-0

COUNTRY VILLA NURSING CTR 340 S ALVARADO ST LOS ANGELES CA 90057 213-4849730 X-0000	2	3 PATIENT CONTROL NO A6697 01-06	4 TYPE OF 212

5 FED TAX NO	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D	8 N-C D	9 C-I D	10 L-R D	11
954301174	060600	063000	25		25		

12 PATIENT NAME	13 PATIENT ADDRESS		
FLOYD, ETHEL	4606 S FIGUEROA	LOS ANGELES	CA 90057

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO	24 CONDITION CODES	31
02111928	F	S	060600		1	1		30			

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a									70	50300	51600	A
b												B
												C

38 UNITED HEALTH PLAN
ATTENTION CLAIMS
1405 WEST IMOERIAL HIGHWAY
INGLEWOOD CA 90303-0000
(800) 544-0088

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	09	2425 00				
b						
c						
d						

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0120	ROOM AND BOARD	145 00		25	6874 37		
2	0250	PHARMACY				674 06		
3	0258	I V ADDITIVES/SUPPLIES				4 46		
4	0270	MED/SURGICAL SUPPLIES				196 96		
5	0300	LABORATORY				515 68		
6	0320	RADIOLOGY-DX				306 45		
7	0412	OXYGEN SUPPLIES				81 00		
8	0420	PHYSICAL THERAPY				1958 00		
9	0424	PHYS THERAPY-EVALUATIONS				88 00		
10	0430	OCCUP. THERAPY SUPPLY				2940 00		
11	0434	OCCU THERAPY-EVALUATIONS				126 00		
12								
13								
14								
15								
16		Medicare primary Please pay co-pay amount of $ 2425 00						
17								
18								
19								
20								
21								
22								
23	0001	TOTAL				13764 98		

50 PAYER	51 PROVIDER	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56
MEDICARE	555397				2425 00	
UHP	555397					

57 DUE FROM PATIENT

58 INSURED S NAME	59 P REL	60 CERT SSN HIC ID NO	61 GROUP NAME	62 INSURANCE GORUP NO
FLOYD, ETHEL	01	4195060214		
FLOYD, ETHEL	1	402702		402702

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN DIAG CD [illegible] 68 CODE 69 CODE 70 CODE OTHER DIAG CODES 72 CODE [illegible] 74 CODE [illegible] DM AG CD [illegible] TE
[illegible] 1130 2300 2481 0389

PC [illegible] PRINCIPAL PROCEDURE DATE

a1 OTHER PROCEDURE CODE DATE

[illegible] PROCEDURE DATE OTHER PROCEDURE CODE DATE

82 ATTENDING PHY ID [illegible]

83 OTHER PHYS ID

OTHER PHYS

4.....1.....2..... . .3 4

00-08-11
15:04:57
VERSION: ZZA0303

PROVIDER NUMBER:
LTC90520G

TRANSACTION TYPE: ELIGIBILITY INQUIRY

RECIPIENT ID:
4195060210

YEAR & MONTH OF BIRTH
1928-02

DATE OF ISSUE:
94-05-01

DATE OF SERVICE:
00-08-11

LAST NAME: FLOYD EVC #: 4972ZN0XNT
UNTY CODE: 19. PRMY AID CODE: 10 1ST
SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE
W/ NO SOC. HEALTH PLAN MEMBER: PHF-L A.
CARE HEALTH PLAN: MEDICAL CALL
(888)452-2273 HCF: UNITED HEALTH PLAN
CALL (800) 544-0088. PCP: CADRIN
GILL CALL: (323)231-5181. UHP
HEALTHCARE: DENTAL CALL (800)544-0085
PART A: B MEDICARE COVERAGE W/HIC
#4195060210A BILL MEDICARE COVERED
SVCS TO MEDICARE BEFORE MEDI-CAL

PATIENT ICN NUMBER / CLAIM #	CLM ST	PAT CNTRL NBR / HIC NUMBER / MRN NUMBER	FROM DT / THRU DT / PT STAT	COST / COVD / NCVD	REPTD CHGS / NCOVD CHGS / DENIED CHGS	DRG NBR	OCD / DRG AMOUNT / DRG OPR AMT	DRG CAP AMT / OUTLIER AMT / DEDUCTIONS	COINS AMT / MSPLIAB AMT / REIMB RATE	MSP PRI PAY / PROF COMP / ESRD AMOUNT	HCPCS AMT / G/R AMOUNT / CONTADJ AMT	INTEREST / PAT REFUND / NET REIMB
FLOYD E M		6697-01-06	606	56	25267 36	000		0 00	5432 00	0 00	0 00	0 00
201945059 6		419506021A	731	56	0 00		0 00	0 00	0 00	0 00	0 00	0 00
1	1		30	0	0 00		0 00	0 00	0 00	0 00	4740 48	15094 88
FLOYD E M		6697-01-06	606	-25	-11415 61	000		0 00	-2425 00	0 00	0 00	0 00
301945059 6		419506021A	630	-25	0 00		0 00	0 00	0 00	0 00	0 00	0 00
2	22		30	0	0 00		0 00	0 00	0 00	0 00	-2116 13	-6874 48
LAU CHAN H		A6709-01-07	701	17	8167 24	000		0 00	485 00	0 00	0 00	0 00
102388083 4		567353534M	718	17	0 00		0 00	0 00	0 00	0 00	0 00	0 00
3	1		02	0	0 00		0 00	0 00	0 00	0 00	1758 07	5924 17
WATSON V		X0084B01-01	119	0	46 47	000		0 00	0 00	0 00	46 47	0 00
102368340 6		550206824D	126	0	0 00		0 00	0 00	0 00	0 00	0 00	0 00
4	1	X0084B01-01	30	0	0 00		0 00	0 00	0 00	0 00	9 30	37 17
DANIELS J		3244B01-07	701	0	213 44	000		0 00	0 00	0 00	201 02	0 00
102224874 2		567286867A	714	0	0 00		0 00	0 00	0 00	0 00	0 00	0 00
5	1		01	0	0 00		0 00	0 00	0 00	0 00	12 42	201 02

PATIENT ICN NUMBER CLAIM #	CLM ST	PAT CNTRL NBR HIC NUMBER MRN NUMBER	THRU DT PT STAT	COST COVD NCVD	REPTD CHGS NCVD CHGS DENIED CHGS	DRG NBR DRG AMOUNT DRG OPR AMT	OCD	DRG CAP AMT OUTLIER AMT DEDUCTIONS	MSPLIAB AMT REIMB RATE	MSP PRI PAY PROF COMP ESRD AMOUNT	HCPCS AMT G/R AMOUNT CONTADJ AMT	INTEREST PAT REFUND NET REIMB
BRIDGEMAN M -		6571-01-06	607	19	9627 60	000		0 00	0 00	0 00	0 00	0 00
1019450585		525209039A	626	19	0 00			0 00	0 00	0 00	0 00	0 00
8	1		01	0	0 00	0 00	0 00	0 00	0 00	0 00	2482 99	7144 61
COHEN L -		3872-01-06	[redacted]	21	8846 36	000		0 00	2037 00	0 00	0 00	0 00
1019450609		428443926A	622	21	0 00			0 00	0 00	0 00	0 00	0 00
9	1		02	0	0 00	0 00	0 00	0 00	0 00	0 00	1359 86	5449 50
DARDON J -		6704-01-06	616	9	1738 67	000		0 00	0 00	0 00	0 00	0 00
1019450586		561062373M	625	9	0 00			0 00	0 00	0 00	0 00	0 00
10	1		04	0	0 00	0 00	0 00	0 00	0 00	0 00	-897 88	2636 55
DIAMOND T -		6620-01-04	[redacted]	30	6783 63	000		0 00	2910 00	0 00	0 00	0 00
2013632819		061018468A	430	30	0 00			0 00	0 00	0 00	0 00	0 00
11	1		30	0	0 00	0 00	0 00	0 00	0 00	0 00	-2378 07	6251 70
DIAMOND T -		6620-01-04	401	-30	-6783 63	000		0 00	-2910 00	0 00	0 00	0 00
3013632819		061018468A	430	-30	0 00			0 00	0 00	0 00	0 00	0 00
12	22		30	0	0 00	0 00	0 00	0 00	0 00	0 00	1786 17	-5659 80
FLOYD E M		6697-01-06	[redacted]	25	11415 61	000		0 00	[redacted]	0 00	0 00	0 00
1019450596		419506021A	630	25	0 00			0 00	0 00	0 00	0 00	0 00
13	1		30	0	0 00	0 00	0 00	0 00	0 00	0 00	2116 13	6874 48
GREENSPON E -		2726-01-06	[redacted]	30	6016 69	000		0 00	[redacted]	0 00	0 00	0 00
1019450604		550129576A	630	30	0 00			0 00	0 00	0 00	0 00	0 00
14	1		30	0	0 00	0 00	0 00	0 00	0 00	0 00	-2981 81	6088 50

C - New HICNum

PLS CHANGE IN THE PATIENT MASTER FILE

HMO/Medicare Risk Insurance Verification Form

Resident Information

Resident Name FLOYD, Ethel M SS# 419-50-6021

Date of Admit 8-11-00

Insurance Information

Name of Insurance UHP

Resident Insurance ID# 402 702 Insurance Policy #

IPA/Medical Group Name Venbro Medical Group

Payor Information

Name of Payor UHP

Address of Payor 1405 W Imperial Hwy
Inglewood, CA 90303

Payor Claims Department Phone Number (800) 544-0088

Eligibility/Benefits Information

Name of person at Ins Co who is supplying information Christine

Phone # of person at Ins Co who is supplying information (800) 544-0088

Effective Date of Policy 5-6-98 Is policy still in effect? (Y) N

If no, date of policy termination _____ (If no, stop here There is no coverage)

Does policy cover Inpatient Skilled Nursing Services? (Y) N

What is the maximum number of days covered under SNF? 0 indicated

What is the maximum dollars payable under SNF benefits? _____

If there are limited days and dollars how many days are currently still available to the resident? _____ How many dollars are available? _____

Does the insurance company require an authorization or tracking number? (Y) N

If yes, what is the authorization/tracking number for this admit? 17935-1

(Same Tracking # as admission 6-6-00, per Ambrosia contact person @ Venbro

HMO/Medicare Risk Insurance Verification Form

Does the policy cover Medicare allowable Part 'B' services? (Y) N
(Note You must obtain an authorization for all Part 'B' services prior to supplying the services)

IPA/Medical Group Information

Name of IPA/Medical Group Ventura Medical Group

Name of person at IPA/Med Grp supplying information Ambrosia

Phone # of person at IPA/Med Grp supplying information (323) 233-1037

Does the IPA require a tracking, referral or authorization number? (Y) N

If yes, what is the number? 17935-1
(Note Facility Case Manager or designated person must continue to monitor these cases and obtain extended authorizations as needed to cover all SNF days)

Case Management

Name of Company handling Case Management UHP Healthcare

Contact Name Bill Malaka Phone # (323) 420-2316 Fax # (323) 820-1655

Additional Information

Comments _____

Attachments Required With Billing

[ ] UB92
[ ] Authorization
[ ] Invoices for Exclusions
[ ] Other _____

Insurance Verification

Completed By _____ Date 8-11-00

RECD JAN 30 2006

FedEx PRIORITY OVERNIGHT MON

emp 404732 27JAN06

TRK# 8474 3274 6556 FORM 0200

Deliver By 30JAN06 A1

90245 -CA-US LAX QZ AVXA

0200

FedEx Retrieval Copy

Customer: Seal only when using a FedEx Ship c

FedEx Express US Airbill 847432746556

1 From

Date 1/27/06 Sender's FedEx Account Number 2721-9878-0

Sender's Name BMC GROUP Phone 310 321-6565

Company WATTSHEALTH FOUNDATION, INC.

Address 1330 E FRANKLIN AVE

City EL SEGUNDO, State CA ZIP 90245

2 Your Internal Billing Reference

3 To

Recipient's Name BMC GROUP CLAIMS & NOTICING AGENT 310321-6565

Company WATTSHEALTH FOUNDATION, INC.

Address 1330 E FRANKLIN AVE

Dept./Floor/Suite/Room

City EL SEGUNDO,

State CA ZIP 90245

4a Express Package Service

Packages up to 150 lbs

1 FedEx Priority Overnight 5 FedEx Standard Overnight 6 FedEx First Overnight

3 FedEx 2Day 20 FedEx Express Saver

4b Express Freight Service

Packages over 150 lbs

7 FedEx 1Day Freight 8 FedEx 2Day Freight 83 FedEx 3Day Freight

5 Packaging

6 FedEx Envelope 2 FedEx Pak 3 FedEx Box 4 FedEx Tube 1 Other

6 Special Handling

Include FedEx address in Section 3

3 SATURDAY Delivery 1 HOLD Weekday at FedEx Location 31 HOLD Saturday at FedEx Location

Does this shipment contain dangerous goods? One box must be checked

No 4 Yes As per attached Shipper's Declaration Yes Shipper Declaration 6 Dry Ice

Dangerous goods (including Dry Ice) cannot be shipped in FedEx packaging Cargo Aircraft Only

Payment Bill to

1 Sender Acct. No. in Section 1 will be billed. 2 Recipient 3 Third Party 4 Credit Card 5

Enter FedEx Acct. No. or Credit Card No. below

FedEx Acct. No. Credit Card No. Exp Date

Total Packages Total Weight Total Charges

†Our liability is limited to $100 unless you declare a higher value. See the FedEx Service Guide for details. Credit Card Auth

8 Sign to Authorize Delivery Without a Signature

By signing you authorize us to deliver this shipment without obtaining a signature and agree to indemnify and hold us harmless from any resulting claims.

467

070103

(R)