

Exhibit 5



UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE RD. SUITE 210
LISLE, IL 60532-4352

May 9, 2016

Mr. Bryan C. Hanson
Senior VP, Exelon Generation Company, LLC
President and CNO, Exelon Nuclear
4300 Winfield Road
Warrenville, IL 60555

SUBJECT: CLINTON POWER STATION—NRC INTEGRATED INSPECTION REPORT
05000461/2016001

Dear Mr. Hanson:

On March 31, 2016, the U.S. Nuclear Regulatory Commission (NRC) completed an integrated inspection at your Clinton Power Station. The enclosed report documents the results of this inspection, which were discussed on April 13, 2016, with Mr. T. Stoner, and other members of your staff.

Based on the results of this inspection, the NRC evaluated one self-revealed issue and three NRC-identified issues under the risk significance determination process as having very low safety significance (Green). The inspectors also evaluated two NRC-identified issues under the traditional enforcement process as having very low safety significance (Severity Level IV). All six issues involved a violation of NRC requirements. These violations are being treated as Non-Cited Violations (NCVs), consistent with Section 2.3.2 of the Enforcement Policy. These NCVs are described in the subject inspection report. Additionally, a licensee-identified violation is listed in Section 4OA7 of this report.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555-0001, with copies to: (1) the Regional Administrator, Region III; (2) the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and (3) the NRC Resident Inspector at the Clinton Power Station.

In addition, if you disagree with the cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Clinton Power Station.

B. Hanson

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In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC's Public Document Room or from the Publicly Available Records System (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

Karla Stoedter, Chief
Branch 1
Division of Reactor Projects

Docket No. 50-461
License No. NPF-62

Enclosure:
IR 05000461/2016001

cc: Distribution via LISTSERV®

As soon as the technicians racked out the breaker associated with CCP 'A' (0AP52E-5D) the main control room received an unexpected annunciator which indicated there was an automatic trip of the running CCP supply fan or the exhaust fan. The licensee determined that racking out the breaker for CCP 'A' disconnected the CCP 'B' auxiliary contact that was used to provide the start permissive signal for the CCP 'B' exhaust fan. This caused the CCP exhaust fan 'B' to trip, resulting in the control room annunciator. The loss of both trains of CCP caused the primary to secondary containment differential pressure to rise and exceed the TS limiting value of 0.25 pounds per square inch differential (psid). The differential pressure reached a value of .411 psid. The licensee entered the action statement for TS 3.6.1.4 which required the restoration of primary to secondary containment differential pressure to within limits in 1 hour. The differential pressure was restored within 40 minutes of the event.

The licensee subsequently performed a walkdown of the breakers at unit substation 'K' and noticed a label on the panel for the CCP 'A' breaker that stated, "The removal or rack out of this breaker will cause the alternate fan breaker to trip if running." The licensee initiated AR 02614832 and performed a root cause analysis that concluded the cause of the event was that the work activity was not properly screened for risk and there was no reference ensuring validation of initial conditions prior to commencing an activity. The proposed corrective actions included updating the planner checklist to ensure steps are created to validate initial conditions and provide training to reinforce the need to properly screen WOs with appropriate risk factors.

Analysis: The inspectors determined that the failure to assess and manage the risk increase of a proposed maintenance activity that impacted CCP, in accordance with 10 CFR 50.65 (a)(4), was a performance deficiency. Specifically, the licensee failed to manage the risk associated with racking out the CCP 'A' breaker, which resulted in the loss of both CCP trains, and led to an increase in primary to secondary containment differential pressure which exceeded the TS value. The performance deficiency was more than minor in accordance with NRC IMC 0612 because it was associated with the maintenance procedure quality attribute of the Barrier Integrity Cornerstone and adversely affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. Specifically, by not properly assessing the risk of racking out the CCP 'A' breaker the licensee did not recognize the CCP 'B' system would be impacted which resulted in exceeding the TS value for primary to secondary containment differential pressure. This constituted an unanalyzed condition and placed the site in a one hour TS action statement. If the station would not have been able to restore the differential pressure within one hour, they would have been required to shut down the plant per TS 3.6.1.4. Using IMC 0609, Attachment 4, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process for Findings at Power," issued June 19, 2012, the finding was screened against the Barrier Integrity Cornerstone and determined to be of very low safety significance (Green) because the finding did not represent an actual open pathway in the physical reactor containment, containment isolation system or heat removal components and it did not involve an actual reduction in function of hydrogen igniters in the reactor containment.

The inspectors identified a cross-cutting aspect in the area of human performance, in the aspect of challenging the unknown, which states, individuals stop when faced with uncertain conditions. Risks are evaluated and managed before proceeding. Specifically, when the licensee was preparing the work package for maintenance on the

CCP system, it was uncertain which activities had already been completed as part of a concurrent evolution. Instead of stopping and validating the configuration of plant equipment, assumptions were made and the risk of the activity was not properly assessed or managed. (H.11)

Enforcement: Title 10 CFR Part 50.65 (a)(4) states, in part, before performing maintenance activities the licensee shall assess and manage the increase in risk that may result from the proposed maintenance activity.

Contrary to the above, on January 19, 2016, before performing the maintenance activity on the unit substation 'K', the licensee did not assess and manage the increase in risk from a proposed maintenance activity. Specifically, the licensee failed to assess and manage the risk associated with racking out the CCP 'A' breaker, which resulted in the loss of both CCP trains and led to an increase in primary to secondary containment differential pressure exceeding the TS value.

The licensee restored the primary to secondary containment differential pressure to within limits within 40 minutes of the event. The licensee also performed a root cause evaluation that determined the cause was that the work activity was not properly screened for risk and there was no reference for ensuring validation of initial conditions prior to commencing a task. The proposed corrective actions to address this issue included creating a checklist to ensure validation of initial conditions is performed and training that reinforces the need to properly screen WO tasks with the appropriate risk factors. Because this violation is of very low safety significance and was entered into the licensee's CAP as AR 02614832, this violation is being treated as an NCV consistent with Section 2.3.2 of the NRC Enforcement Policy (**NCV 05000461/2016001-05: Failure to Assess and Manage Risk Increase for a Proposed Maintenance Activity**).

4OA5 Other Activities

.1 Review of 10 CFR 72.212(b) Evaluations at Operating Plants (60856.1)

a. Inspection Scope

The licensee has planned to place its first loaded spent fuel dry storage casks on its independent spent fuel storage installation (ISFSI) pad in late summer or early fall of this year. Title 10 CFR 72.212(b)(5)(ii) requires that licensees perform written evaluations, before use, which establish that cask storage pads and areas have been designed to adequately support the static and dynamic loads of the stored casks, considering potential amplification of earthquakes through soil-structure interaction, and soil liquefaction potential or other soil instability due to vibratory ground motion.

The inspectors evaluated the licensee's soil and ISFSI pad engineering design evaluations to verify the licensee's compliance with the cask Certificate of Compliance, 10 CFR Part 72 requirements, and industry standards.

The licensee planned to utilize the Holtec HI-STORM FW dry cask storage system. A single three-foot-thick reinforced concrete pad is capable of supporting 6 HI-STORM casks in a 6-by-6 array. The pad is 104 feet wide and 104 feet long. The licensee designed and constructed the ISFSI pad as an important-to-safety structure.

The inspectors reviewed the licensee's soil investigation reports and calculations documenting the engineering properties and design soil profile of the ISFSI site based on new geotechnical investigations of the ISFSI areas combined with the data in the plant USAR. The inspectors reviewed documents to verify that the pad design duly addressed geological and hydrological considerations using the information from the earlier and the new soil investigations. The inspectors reviewed licensee's liquefaction analysis to verify seismic input and safety factors were consistent with Regulatory Guidance 1.198, "Procedures and Criteria for Assessing Seismic Soil Liquefaction at Nuclear Power Plant Sites."

The inspectors reviewed documents for the generation of new seismic acceleration time histories from the seismic ground motion spectra for the reactor site to be used as inputs for the ISFSI analyses. The inspectors reviewed the soil structure interaction analysis methodology and calculations to verify adequacy of the soil / pad / cask analytical model, the soil profile, modeling for interfaces, boundary conditions, and consideration of uncertainties of the soil investigation data. The inspectors reviewed the ISFSI pad structural design to verify the methodology, load factors and acceptance criteria, consideration of long term total and differential settlements, adequacy of safety factors under static and dynamic loading, and consideration for sequential and partial loading. The inspectors reviewed evaluations for determination of static and ultimate soil bearing capacities, and safety factors under worst case static and dynamic loads.

The inspectors reviewed the licensee's cask haul path evaluations to verify that maximum expected loads were considered. Inspectors interviewed licensee personnel and performed walkdowns of the haul path and the ISFSI areas to verify that licensee had reviewed the haul path for the right-of-way requirements and potential interferences from nearby structures and overhead lines. The inspectors also reviewed documentation evaluating buried utilities beneath or near the haul path, staging areas, and the ISFSI pad area to verify that affected utilities were identified, evaluated, and protected through design of additional reinforcements where needed.

b. Findings

No findings were identified.

.2 Onsite Fabrication of Components and Construction of an ISFSI (60853)

a. Inspection Scope

The inspectors evaluated whether construction activities for the ISFSI concrete storage pad complied with specifications contained in the licensee's approved design evaluation, approved design drawings, WOs, and applicable industry standards. The inspectors also reviewed select material documentation, concrete documentation, and personnel certification records.

The inspectors reviewed HI-2135703, "Clinton Power Station [ISFSI] Construction Specifications," Revision 4. HI-2135703 described the minimum requirements for construction activities related to installation of the ISFSI pad. The inspectors also reviewed HSP-186, "Aggregate and ready mixed concrete testing requirements for [important-to-safety] ITS "B" Applications," Revision 20, which further established cast-in-place concrete construction and material testing requirements for the ISFSI pad.

The NRC inspectors reviewed the design drawings of the ISFSI pad. Following placement and satisfactory compaction of the engineered fill, placement of rebar, and securing of formwork, the NRC inspectors performed inspections of the ISFSI pad prior to concrete placement.

The inspectors reviewed the licensee's concrete mix design to ensure compliance with the applicable codes and standards committed to in the licensee's design. The inspectors reviewed the licensee's exposure classifications of the ISFSI pad to ensure compliance with the durability requirements of American Concrete Institute 318, "Building Code Requirements for Structural Concrete." The inspectors reviewed the licensee's specified strength, water-to-cement ratio, slump, and air content. The inspectors reviewed the licensee's selection and testing of mix design components, including cement, potable water, fine aggregate, coarse aggregate, and admixtures.

The ISFSI pad was constructed in three segments allowing separate continuous placements of concrete. The inspectors observed concrete placement for the second segment of the storage pad and reviewed curing operations for the first segment of the storage pad. The inspectors observed the licensee's process for performing concrete testing in the field and sampling concrete for laboratory break testing.

The inspectors reviewed the 28-day concrete compressive strength test results taken from the storage pad to ensure they met the minimum strength of 4,500 pounds per square inch (psi) and maximum of 5,500 psi as specified by the design requirements. The inspectors verified that the licensee documented in the CAP when tests did not meet the specified design requirements.

b. Findings

No findings were identified.

3. Follow Up Inspection for Three or More Severity Level IV Traditional Enforcement Violations in the Same Area in a 12-Month Period (92723)

a. Inspection Scope

The inspectors assessed the licensee's evaluation of five SL IV violations, which occurred within the area of impeding the regulatory process, from July 1, 2014, through September 30, 2015. These violations were documented in NRC Inspection Reports as: (1) NCV 05000461/2014004-05; (2) NCV 05000461/2014004-06; (3) NCV 05000461/2014005-04; (4) NCV 05000461/2015008-01; and (5) NCV 05000461/2015003-03.

The inspection objectives were to provide assurance that:

- The licensee understood the causes of multiple SL IV traditional enforcement violations;
- The licensee identified the extent of condition and extent of cause of multiple SL IV traditional enforcement violations; and
- The licensee's corrective actions to address the traditional enforcement violations were sufficient to address the causes.

The inspectors reviewed: (1) the various licensee CAP documents including Apparent Cause Evaluation (ACE) 2511697, "Severity Level IV Violations Cause Evaluation," and ACE 2552999, "NRC Debrief Potential Violation on Railroad Bay and Secondary Containment"; (2) the licensee's Check-In Self-Assessment Report 02552387, "Pre-IP 92723 Inspection—Follow up Inspection for Three or More Severity Level IV Traditional Enforcement Violations in the Same Area in a 12-Month Period"; (3) the licensee's CAP; and (4) the licensee's condition reports associated with the violations.

b. Findings

Inadequate Extent of Condition Associated with an Apparent Cause Evaluation

Introduction: The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion II, "Quality Assurance Program," for the failure to follow a Quality Assurance Program implementing procedure. Specifically, the licensee failed to identify the extent of a lack of proficiency in applying the licensing basis for SSCs when performing 10 CFR 50.59 evaluations.

Description: On October 9, 2015, the licensee completed ACE 2552999, "NRC Debrief Potential Violation on Railroad Bay and Secondary Containment," in accordance with Station Procedure PI-AA-125-1003, "Apparent Cause Evaluation Manual," Revision 2. The licensee documented the evaluation using Attachment 2 of PI-AA-125-1003. The ACE assessed the NRC identified violation regarding a deficient 10 CFR 50.59 evaluation that did not provide a basis describing why extending the secondary containment boundary to the fuel building outer railroad bay door would not result in a more than minimal increase in the likelihood of occurrence of a malfunction of an SSC important to safety as described in the USAR.

Section 4.4.1, Step 2 of PI-AA-125-1003 stated "analyze each causal factor to determine the apparent causes and contributing causes." The licensee determined the apparent cause to be "lack of proficiency in applying licensing properties as if they were technical properties."

Section 4.4.1, Step 3 of PI-AA-125-1003 stated "determine the extent of condition." The extent of condition review included the completed 10 CFR 50.59 evaluation related to the ISFSI project, CL-2014-E-011, for the rigging and floor loading evaluation to support upgrading the fuel building crane, and one 10 CFR 50.59 screening, CL-2015-S-018, which discussed a procedural change related to the extension of the secondary containment. The extent of condition review for the completed 10 CFR 50.59 evaluation concluded that it did "not relate to the misapplication of understanding for secondary containment" and the extent of condition review for the 10 CFR 50.59 screening simply stated that there was a standing order in place such that the procedural change was not yet implemented.

The ACE report quality checklist documented that the investigation team used Attachment 19 of PI-AA-125-1006, "The Investigation Techniques Manual," Revision 2, to adequately and accurately address the extent of condition. Attachment 19 provided instructions for performing adequate extent of condition reviews, stating to "focus on the actual condition and its existence in other places." In addition, Attachment 19 provided questions for the investigation team to consider when conducting an extent of condition

review. One group of questions under human performance asked: "is that all he/she did today? Or this week?" and "what other tasks did he/she do that we should be concerned about?"

Station Procedure PI-AA-125 defined extent of condition, in part, as the "extent to which the actual condition exists with other plant processes, equipment, or human performance." The apparent cause evaluated for extent of condition was a lack of proficiency in the understanding of the licensing basis for secondary containment. The licensee's extent of condition was narrowly focused on evaluations specific to secondary containment rather than a broader scope of evaluations for different SSCs or other evaluations performed by the individuals that performed the evaluation on secondary containment. Attachment 19 provided guidance for assessing other tasks performed by the individuals associated with the secondary containment evaluation; however, the licensee did not include a determination to assure licensing properties were applied appropriately in other 10 CFR 50.59 evaluations performed by those individuals.

The licensee documented this issue into their CAP as AR 02641397. Immediate corrective actions included a review of the extent of condition performed by the engineering department and a recommended action of expanding the scope of the review to include additional 10 CFR 50.59 evaluations.

Analysis: The inspectors determined the failure to follow a Quality Assurance Program implementing procedure and determine the extent of condition in accordance with procedure PI-AA-125, "Corrective Action Program," Revision 2, was a performance deficiency. Specifically, the licensee failed to identify the extent of a lack of proficiency in applying the licensing basis for SSCs when performing 10 CFR 50.59 evaluations. The performance deficiency was more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," dated September 7, 2012, because if left uncorrected the performance deficiency has the potential to lead to a more significant safety concern. Specifically, if the extent of condition review is too narrowly assessed there is the potential for other safety significant systems to have been impacted by a lack of proficiency in applying the licensing basis for SSCs, and therefore, may not perform their intended safety function as defined in the USAR. Using IMC 0609, Attachment 4, "Initial Characterization of Findings," and Appendix A, "The Significance Determination Process for Findings at Power," issued June 19, 2012, the finding was screened against all cornerstones and determined to be of very low safety significance (Green) because there was no reasonable indication that the criteria in Appendix A requiring a detailed risk evaluation was met. The inspectors assessed all cornerstone screening questions within IMC 0609, Appendix A, based on guidance in IMC 0609 that states, in part, "If more than one cornerstone is affected, the screening questions in all the affected cornerstones apply" and because not knowing the extent of the lack of proficiency in applying of licensing basis with respect to 10 CFR 50.59 evaluations has the potential to affect all cornerstones.

The inspectors determined this finding affected the cross-cutting area of human performance, in the aspect of procedure adherence, where individuals follow processes, procedures and work instructions. Specifically, the licensee did not effectively adhere to all available portions of CAP procedures, which led to a narrowly focused extent of condition. (H.8)

Enforcement: Title 10 CFR 50, Appendix B, Criterion II, "Quality Assurance Program," requires, in part, that "the applicant shall establish at the earliest practicable time, consistent with the schedule for accomplishing the activities, a Quality Assurance Program which complies with the requirements of this appendix. This program shall be documented by written policies, procedures, or instructions and shall be carried out throughout plant life in accordance with those policies, procedures, or instructions."

Section 4.4.1, Step 3 of PI-AA-125-1003, Revision 2, "Apparent Cause Evaluation," states, in part, "determine the extent of condition." Step 2.18 of PI-AA-125, Revision 2, "Corrective Action Program," states, in part, that the extent of condition is "the extent to which the actual condition exists with other plant processes, equipment, or human performance."

Contrary to the above, on October 9, 2015, the licensee failed to carry out the corrective actions portion of their Quality Assurance Program in accordance with Procedure PI-AA-125-1003, Revision 2, "Apparent Cause Evaluation," Step 3 to "determine the extent of condition," and the "extent of condition as defined in Procedure PI-AA-125, Revision 2, "Corrective Action Program," Step 2.18 as "the extent to which the actual condition existed with other plant processes, equipment, or human performance." Specifically, the licensee failed to identify the extent of a lack of proficiency in applying the licensing basis for SSCs when performing 10 CFR 50.59 evaluations. The corrective actions in response to this issue included increasing the scope of the extent of condition to include other evaluations performed by the individuals associated with the "lack of proficiency." Because this finding was of very low safety significance and was entered into the licensee's CAP as AR 02641397, this violation is being treated as an NCV, in accordance with Section 2.3.2 of the NRC Enforcement Policy (**NCV 05000461/2016001-06: Inadequate Extent of Condition Associated with an ACE**).

c. Observations

During the inspection, the inspectors noted that the narrowly focused extent of condition review for ACE 02552999 had resulted in the development of similarly, narrowly focused corrective actions. The inspectors determined that the development of the narrowly focused corrective actions was not a violation of NRC requirements. However, the licensee's CAP procedure states, in part, that "if at any time (e.g., during an investigation, review of a CA closure, review of a previous CR) a SCAQ [significant condition adverse to quality] or CAQ [condition adverse to quality] or any question of either current or past Operability/Reportability arises, then initiate an Issue Report." Therefore, additional corrective actions may be needed once the licensee completed an expanded scope extent of condition review that included additional 10 CFR 50.59 evaluations/screenings.

4OA6 Management Meetings

.1 Exit Meeting Summary

On April 13, 2016, the inspectors presented the inspection results to Mr. T. Stoner, Site Vice President, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

.2 Interim Exit Meetings

Interim exit was conducted for:

- The inspection results for the follow up inspection for three or more Severity Level IV traditional enforcement violations in the same area in a 12-month period with Mr. B. Kapellas, Plant Manager, on March 18, 2016.

The inspectors confirmed that none of the potential report input discussed was considered proprietary. Proprietary material received during the inspection was returned to the licensee.

4OA7 Licensee-Identified Violations

The following violation of very low significance (Green) was identified by the licensee and is a violation of NRC requirements which meets the criteria of the NRC Enforcement Policy for being dispositioned as an NCV.

- Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," requires activities affecting quality be prescribed by documented instructions, procedures and drawings, of a type appropriate to the circumstances and shall be accomplished in accordance with those instructions, procedures and drawings. The NDE task notes for WO 1887754, "NDE UT of RHR 'A'," stated that the UTs were to be performed as found, and therefore, "they were to be performed before hanging clearances, valve stroking, or other system manipulations such as fill and flow path verifications." Contrary to this, on January 20, 2016, the licensee failed to perform an as found UT of RHR 'A' prior to hanging clearances or performing valve stroking or other system manipulations such as fill and flow path verifications. The licensee documented the issue in their CAP as AR 02614744. The inspectors determined that this issue was of very low safety significance because the finding: (1) was not a deficiency affecting the design or qualification of a mitigating system; (2) did not represent a loss of system and/or function; (3) did not represent an actual loss of function of a single train for greater than its TS allowed outage time; and (4) does not represent an actual loss of function of one or more non-TS trains of equipment designated as high safety-significant in accordance with the licensee's maintenance rule program for greater than 24 hours.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

R. Bair, Chemistry Manager
B. Kapellas, Plant Manager
M. Friedmann, Emergency Preparedness Manager
B. Brooks, Security Manager
J. Cunningham, Maintenance Director
C. Dunn, Operations Director
N. Hightower, Radiation Protection Manager
R. Champley, Shift Operations Superintendent
C. Propst, Work Management Director
J. Ward, Performance Improvement Manager
D. Shelton, Regulatory Assurance Manager
S. Gackstetter, Engineering Director
S. Minya, Operations Training Manager
T. Stoner, Site Vice President
M. Heger, Senior Manager Plant Engineering
T. Krawyck, Senior Manager Plant Engineering

U. S. Nuclear Regulatory Commission

K. Stoedter, Chief, Reactor Projects Branch 1
W. Schaup, Clinton Senior Resident Inspector
E. Sanchez-Santiago, Clinton Resident Inspector

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened/Closed

05000461/2016001-01	NCV	Failure to Identify a Degraded Safety-Related Support (Section 1R04)
05000461/2016001-02	NCV	Operability Determination Failed to Examine Test Failures (Section 1R15.1.b(1))
05000461/2016001-03	SLIV	Failure to Report a Condition that Could Have Prevented Fulfillment of a Safety Function (Section 1R15.1.b(2))
05000461/2016001-04	SLIV	Failure to Report a Condition Prohibited by Technical Specifications (Section 4OA2)
05000461/2016001-05	NCV	Failure to Assess and Manage Risk Increase for a Proposed Maintenance Activity (Section 4OA3)
05000461/2016001-06	NCV	Inadequate Extent of Condition Associated with an ACE (Section 4OA5)