STATE OF VERMONT

GREEN MOUNTAIN CARE BOARD

Purchase of	)	
Franklin County Rehab Center, LLC	)	**Docket No. GMCB-012-15con**
	)	

CERTIFICATE OF NEED

ADDITIONAL INFORMATION REQUESTED

Please find the answers to the following questions asked in the letter from the Green Mountain Care Board dated October 17, 2016.

1. **During the application review period for a previous certificate of need (Docket No. GMCB-019-14con, purchase of Redstone Villa) you provided documentation for two incidents where the Medical Director, Dr. Tieg Marco, was reprimanded by the Department of Health's Board of Medical Practice. Provide follow-up documentation that Dr. Marco has satisfied the requirements of the Orders of the Board of Medical practice.**

   The Medical Director had two incidents that he has been reprimanded by the Department of Health. The reprimands did not occur at Franklin County Rehab Center or our other building, The Villa Rehab Center. He currently is Medical Director at other Skilled Nursing Facilities and Residential Care Homes within Franklin and Chittenden County. I have attached the reprimands and he has explained the circumstances and we are confident that he provides quality care to our facilities. The reprimands were isolated events. He currently spends two days a week at Franklin County Rehab Center. Please see **(Attachment 1)**

2. **Provide detail of projected Patient Service Revenue by revenue per day for 2016, 2017, 2018, 2019.**

   Please see the detail of projected Patient Service Revenue per day for the following years from 2016 through 2019 outlined below. This information can also be found in Note 4 of the projections filed with the Certificate of Need.

FY-2016 is projected at a 2% increase over 2015 actual numbers - nothing is projected to change under new ownership - 2015 actual numbers are in the 2015 column

FY-2017 is projected at a 2% increase over 2016 actual numbers - nothing is projected to change under new ownership

FY-2018 is projected at a 2% increase over 2017 actual numbers - nothing is projected to change under new ownership

FY-2019 is projected at a 2% increase over 2018 actual numbers - nothing is projected to change under new ownership

3. **Provide detail of Private Pay rate per day for historical 2014-2015 and the projected rate for 2016, 2017, 2018, and 2019.**

Please find the detail of the Private Pay rate per for historical 2014 and 2015 and the projected rate for the years 2016 through 2019 below.

2014 - the actual average private room rate was $280.60 (1,274,136 / 4,540) (which includes multiple rates for semi-private versus private, changes during year, showers versus no showers, etc. ranging from $263/Day to $385/day)

2015 - the actual average private room rate was $302.80 (1,397,753 / 4,616) (which includes multiple rates for semi-private versus private, changes during year, showers versus no showers, etc. ranging from $279 /day to $394 / day)

2016 - adds 2% to the average rate from 2015 as indicated in the assumptions to the projections which would equate to $308.80

2017 - adds 2% to the average rate from 2016 as indicated in the assumptions to the projections which would equate to $314.90

2018 - adds 2% to the average rate from 2017 as indicated in the assumptions to the projections which would equate to $321.10

4. **Provide the daily Nursing Hours per Patient Day used throughout the pro-forma period by position and by shift.**

Please see table below for daily Nursing Hours per Patient Day used throughout the pro-forma. Please Note as indicated in the projections nothing is projected to change due to the change in ownership.

	2014	2015	2016	2017	2018	2019
Hours						
RN	22,303.66	25,026.31	25,026.31	25,026.31	25,026.31	25,026.31
MDS coordinator	3,016.84	3,110.25	3,110.25	3,110.25	3,110.25	3,110.25
LPN	19,547.36	15,621.66	15,621.66	15,621.66	15,621.66	15,621.66
LNA	78,473.31	82,459.28	82,459.28	82,459.28	82,459.28	82,459.28
Total	123,341.17	126,217.50	126,217.50	126,217.50	126,217.50	126,217.50
Days	21,636	21,636	21,636	21,636	21,636	21,636
Hours per day						
RN	1.03	1.16	1.16	1.16	1.16	1.16
MDS coordinator	0.14	0.14	0.14	0.14	0.14	0.14
LPN	0.90	0.72	0.72	0.72	0.72	0.72
LNA	3.63	3.81	3.81	3.81	3.81	3.81
Total HRS	5.70	5.83	5.83	5.83	5.83	5.83

5. **Please indicate whether the applicant intends to participate in any health care reform models (ACO, bundled payments, value based purchasing).**

   Franklin County Rehab Center is participating with ONECARE and the Vermont Accountable Care Organization for Medicare and Medicaid Next Generation. Please see Attached signed Provider Agreements. **(Attachment 2)**

6. **Confirm whether the Medicare Net Patient Revenue includes a reduction based upon the CMS Sequestration Adjustment of 2%.**

Yes, the projections are based on 2015 actual (as indicated in the assumptions) and 2015 revenues are net of the 2% sequestration so the 2016-2019 projected numbers are by default net of the sequestration.

7. **Provide the number of Admissions by Payer for historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019.**

Please see Table below providing the number of Admissions by Payer for historical period of 2014-2015 and for the projected years of 2016-2019. Please Note as indicated in the projections nothing is projected to change due to the change in ownership.

Admissions	2014	2015	2016	2017	2018	2019
Private	18	10	10	10	10	10
Medicaid	18	15	15	15	15	15
Medicare	240	206	206	206	206	206
Other	22	19	19	19	19	19
Total	298	250	250	250	250	250

8. **Provide the Average Revenue per Bed per Payer per Year as compared to the Occupancy rate assumptions for the historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019.**

Please see Table below which shows Revenue per Payer per Year as compared to the Occupancy rate assumptions for the historical period 2014-2015 and projected for years 2016-2019. Please Note as indicated in the projections nothing is projected to change due to the change in ownership (except a 2% inflationary increase)

	2014	2015	2016	2017	2018	2019
Total Revenue (before bad debts)	7,413,481	7,787,741	7,943,496	8,102,366	8,264,413	8,429,701
# of beds	64	64	64	64	64	64
Average revenue per bed	115,836	121,683	124,117	126,599	129,131	131,714
Occupancy	92.82%	92.62%	92.62%	92.62%	92.62%	92.62%

9. **Provide the projected Medicare Average Length of Stay for the historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019**

Please find the below table that shows projected Average Length of Stay for historical period of 2014-2105. Please Note as indicated in the projections nothing is projected to change due to the change in ownership

Medicare Length of Stay Days	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
	28.43	30.27	30.27	30.27	30.27	30.27

10. **Provide the number of FTE's assigned to the line items Salary-Administrator and Salary-Other Admin for the historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019.**

Admin FTES	2014	2015	2016	2017	2018	2019
Administrator	1.00	1.00	1.00	1.00	1.00	1.00
Asst Administrator	1.09	1.04	1.04	-	-	-
Transitional consulting - Phil Condon	-	-	-	1.00	-	-
Human Resources	0.86	1.00	1.00	1.00	1.00	1.00
Business manager/Bookkeeper/Other	2.76	3.32	3.32	3.32	3.32	3.32
Total in Admin Salary expenses	5.71	6.36	6.36	6.32	5.32	5.32
DON	1.08	1.08	1.08	1.08	1.08	1.08
Pharmacist	0.03	0.03	0.03	0.03	0.03	0.03
Med Director	0.10	0.10	0.10	0.10	0.10	0.10
Total to tie to Table 9	6.92	7.57	7.57	7.53	6.53	6.53

11. Provide the job descriptions of the FTE's in the Salary- Administrator and Salary-Other Admin for the historical period 2014-2015 and the projected for years 2016, 2017, 2018, and 2019.

Please see attachment for Job Descriptions for the FTE's in Salary Administrator and Salary Other in Admin for historical period and projected years of 2016, 2017, 2018, and 2019. (**Attachment 3**)

12. Application Table 1: "Projected Costs" and Table 2: "Debt Financing Arrangement, Sources & Uses of Funds." Both need to be filled out for Transfer of Ownership transaction.

Tables 1 and 2 are not applicable. All the numbers are zero. No fixed assets are being bought because of this ownership transfer and no debt is being incurred.

13. Provide the FTE's associated with the Dietary department.

	2014	2015	2016	2017	2018	2019
Dietary FTEs	7.72	7.79	7.79	7.79	7.79	7.79

14. Provide a list of what is included in Employee Benefits for the historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019 as reflected in the pro-forma.

Please see listing of Employee Benefits in **(Attachment 4).** The provided list is for the historical period of 2014-2105 and will not change for the projected years 2016, 2017, 2-18, and 2019. The benefits will continue to be the same for the projected years of 2017-thought 2019.

15. Provide the annual Health Insurance and Retirement expenses for the historical period 2014-2015 and projected for years 2016, 2017, 2018, and 2019.

Note - as indicated in the projections nothing is projected to change due to the change in ownership (except a 2% inflationary increase)

	2014	2015	2016	2017	2018	2019
Health Insurance	122,530	116,955	119,294	121,680	124,114	126,596
Retirement	50,178	51,916	52,954	54,013	55,094	56,196

16. **Provide the methodology and calculations for Bad Debt and A/R Allowance for 2014-2019 as reflected in the pro-forma period.**

In 2014 and 2015 Franklin County Rehab Center (FCRC) had a couple of bad years for collections and there were larger bad debt write-offs. The Accounts Receivable person for those years is no longer employed in that position. Franklin County Rehab Center hired a person that has an extremely strong financial background and operates as a Chief Financial Officer. She has significantly set up systems and is very astute with collections and complex billing. In 2014 the company went through a very large computer transition to Electronic Health Records, and Financial software conversion. This specific time frame also caused additional problems with billing and collections which ran into 2015.

2016 will not have these kind of problems and it is management's best estimate there will only be around $50,000 in bad debts inflated by 2% inflationary factor each year going forward making bad debts $51,000, and then $52,020 and then $53, 060 for 2017-2019 respectively. The allowance for bad debts is included in the net Accounts receivable number and is based on the audited 2015 balance of $42,000 at 12/31/2-15. It is inflated annually (as in the Accounts receivable balance itself) by the projected inflationary factor off 2%.

17. **Provide the date and annual payment amounts on the promissory note. How many annual payments will be made?**

This is not a loan that has any bearing on the Projections. It is between the individuals that are transferring membership interest between themselves. This loan will be as soon as the GMCB approves the sale. However, the annual payments are not anticipated to start until January 2018.

	Phil	Trust	Coleen	Total
Est Value per Commiss letter	1,994,746.96	673,901.00	26,956.04	2,695,604.00
				-
Gift to Coleen & Callie	(1,200,000.00)	-	-	(1,200,000.00)
				-
Loan	794,746.96	673,901.00	26,956.04	1,495,604.00
Monthly Pmt at 4% - 180 mo	5,878.65	4,984.76		

18. Provide the note payable roll forward schedule including total payments, total interest, and total principle with beginning and ending dates.

Again, this has no bearing on Franklin County Rehab. This is a membership interest being transferred between the former owners and the new owners. (Related Parties) This will not be debt on Franklin County Rehab's books. This debt will be paid individually from distributions. In the event there are not allowable distributions that the new owners can take to make the debt payments, they will be limited to the amount that can be taken as distributions (similar to a HUD Surplus Cash Loan as HUD will be limiting the new owners as to what they can take based on HUD surplus cash calculations). Franklin County Rehab is at no risk for this debt. Please see attached amortization schedules for the "estimated" loan amount to Phil Condon and to the Estate of Tressa Condon. Please see **(Attachment 5)**

ATTACHMENT 1

BOARD OF MEDICAL PRACTICE

In re: Teig D. Marco, Jr., M.D.	)	Docket No. MPC 052-0514

STIPULATION AND CONSENT ORDER

NOW COME Teig D. Marco., M.D., and the State of Vermont, by and through Vermont Attorney General William H. Sorrell, and hereby stipulate and agree to the following in the above-captioned matter:

1. Teig D. Marco, M.D. ("Respondent") holds Vermont medical license number 042-0007992 originally issued by the Vermont Board of Medical Practice on July 3, 1989.
2. Jurisdiction in this matter rests with the Vermont Board of Medical Practice ("the Board"), pursuant to 26 V.S.A. §§ 1353-1357, 3 V.S.A. §§ 809-814, and other authority.

FINDINGS OF FACT

3. The Board opened the Docket No. MPC 052-0514 matter in May 2014 upon receipt of information concerning Respondent. The matter was assigned to the Central Investigative Committee ("the Committee") of the Board.
4. The Committee's investigation revealed that in December 2013 Respondent was providing medical care to nursing home patients when he was approached at the nursing home by a medical professional (the "Patient") with whom he had a professional relationship. Patient asked Respondent if his practice group was taking new patients as Patient needed a new primary care provider.
5. Respondent advised Patient that there were providers at his practice who would be willing to see Patient. Patient had an appointment with a provider at Respondent's

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practice, but was ultimately dismissed from the practice once Patient's opioid prescription history was discovered via a query of the Vermont Prescription Monitoring System ("VPMS").

6. Respondent referred Patient to a pain clinic.
7. Despite receiving some background information from his practice concerning Patient's VPMS query results, Respondent did not attempt to obtain a copy of the query, nor did he query VPMS to view Patient's controlled substance prescription history.
8. Patient again approached Respondent at the nursing home and asked if he would write prescriptions for opioid pain medications and antidepressants until Patient could find another provider. Respondent agreed to write these prescriptions based on his professional relationship with Patient.
9. On December 6, 2013, Respondent provided Patient with a prescription for 90 tablets of hydrocodone – acetaminophen 7.5-325. Prior to writing this prescription, Respondent failed to conduct a physical exam, obtain a history or query Patient's history on VPMS. At no time prior or subsequent to providing Patient with the prescription did Respondent create any medical records to document his treatment, nor did he check Patient's history on VPMS.
10. On January 2, 2014, Respondent provided Patient with a prescription for 90 tablets of hydrocodone – acetaminophen 7.5-325. Prior to writing this prescription, Respondent did not conduct a physical exam, obtain a history, or query Patient's history on VPMS.
11. At no time prior or subsequent to providing Patient with the hydrocodone-acetaminophen prescription did Respondent create any medical records to document his treatment, nor did he check Patient's history on VPMS.

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12. On January 31, 2014, Respondent provided Patient with a prescription for 90 tablets of hydrocodone – acetaminophen 7.5-325.

13. Prior to writing this prescription, Respondent did not conduct a physical exam, obtain a history, or query Patient's history on VPMS.

14. At no time prior or subsequent to providing Patient with the hydrocodone-acetaminophen prescription did Respondent create any medical records to document his treatment, nor did he check Patient's history on VPMS.

CONCLUSIONS OF LAW

15. It is unacceptable medical practice for a licensee to write an initial prescription for opioid medication to a new patient without conducting a physical examination, obtaining a history, querying VPMS, and documenting his treatment. Such conduct may constitute unacceptable patient care and the failure to conform to the essential standards of acceptable and prevailing practice in violation of 26 V.S.A. §§ 1354(b)(1) and (2).

16. Respondent acknowledges that it is the Board's position that if the State were to file charges against him, it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354 (b)(2).

17. Respondent agrees that the Board may enter as its facts and/or conclusions paragraphs 1 through 14 above, and further agrees that this is an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purposes set forth in this agreement.

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18. Therefore, in the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into the instant agreement with the Board. Respondent enters no further admission here, but to resolve this matter without further time, expense and uncertainty; he has concluded that this agreement is acceptable and in the best interest of the parties.

19. Respondent acknowledges that he is knowingly and voluntarily entering into this Stipulation and Consent Order with the Board. He acknowledges he has had the advice of counsel regarding this matter, and in the review of this Stipulation and Consent Order. Respondent is fully satisfied with the legal representation he has received in this matter.

20. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross-examine witnesses, and to offer evidence of his own to contest any allegations by the State.

21. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be administratively closed by the Board. Thereafter, the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

22. This Stipulation and Consent Order is conditioned upon its acceptance by the Vermont Board of Medical Practice. If the Board rejects any part of this document, the entire agreement shall be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board

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rejects any part of this agreement, none of its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence, and it shall be without prejudice to any future disciplinary proceeding and the Board's final determination of any charge against Respondent.

23. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to: the Federation of State Medical Boards Board Action Databank, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Data Bank. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

24. The parties therefore jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Board, it may enter an order implementing the terms and conditions herein.

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ORDER

WHEREFORE, based on the foregoing, and the consent of Respondent, it is hereby ORDERED that:

a. Respondent shall be reprimanded for the conduct set forth above;

b. No later than one year from the date of approval of this Stipulation and Consent Order, Respondent shall successfully complete a continuing medical education course approved by the Central Investigative Committee of the Board that addresses medical ethics, boundaries and professionalism. Respondent shall seek the Committee's approval of the proposed CME course no later than 60 days prior to the start date of the course. Respondent shall complete the course within one year of the entry of this Stipulation and Consent Order. Upon Respondent's successful completion of the CME course, he shall provide the Committee with proof of attendance. Respondent shall also provide a brief written narrative of the CME course to the Central Committee which will document what he learned from the course, and how he will apply that knowledge to his practice. Respondent shall provide the proof of attendance and written narrative to the Committee within 30 days of completion of the CME course. Respondent shall be solely responsible for all costs associated with the CME course; and

c. Respondent acknowledges that as a prescriber of controlled substances in Vermont he is responsible for knowing when to use VPMS in accordance with state law, state regulations, and the standard of care. At a minimum, Respondent shall check VPMS when prescribing controlled substances in the following circumstances as

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required by Act 205 of 2014, regardless of whether a patient resides in a nursing home:

(1) at least annually for patients receiving ongoing treatment with an opioid Schedule II, III or IV controlled substance;

(2) when starting a patient on Schedule II, III or IV controlled substances for nonpalliative long-term pain therapy of 90 days or more;

(3) the first time prescribing an opioid Schedule II, III, or IV controlled substance to treat chronic pain; and

(4) prior to writing a replacement prescription for a Schedule II, III, or IV controlled substances.

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11/3/14

SIGNATURES

DATED at Montpelier, Vermont, this 3rd day of November, 2014.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

By: Kassandra P. Aristide
Kassandra P. Aristide
Assistant Attorney General
Office of the Attorney General
109 State Street
Montpelier, VT 05609

DATED at Fair Haven, Vermont, this 3rd day of November, 2014.

Teig D. Marco, M.D.

Respondent

Approved as to form:

DATED at Burlington, Vermont, this 3 day of Nov., 2014.

Ritchie E. Berger, Esq.
Dinse, Knapp & McAndrew, P.C.
209 Battery Street
P.O. Box 988
Burlington, VT 05402

Counsel for Respondent

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11/3/14

AS TO TEIG D. MARCO, M.D.

APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Dated: December 3, 2014

ENTERED AND EFFECTIVE: December 3, 2014

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11/3/14

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Teig D. Marco, M.D.	)	Docket No. MPC 158-1012

STIPULATION AND CONSENT ORDER

NOW COME Teig D. Marco, M.D. and the State of Vermont, by and through Attorney General William H. Sorrell, and hereby stipulate and agree to the following in the above-captioned matter:

1. Teig D. Marco, M.D. ("Respondent") holds Vermont medical license number 042.0007992, first issued on July 3, 1989. Respondent is an internist who sees nursing home patients at several Vermont nursing homes including St. Albans Health and Rehabilitation where he serves as Medical Director.

2. Jurisdiction in this matter vests with the Vermont Board of Medical Practice ("Board") pursuant to 26 V.S.A. §§ 1353-1357, 3 V.S.A §§ 809-814, and other authority.

FINDINGS OF FACTS

3. In October 2012, the Central Investigative Committee of the Board of Medical Practice opened an investigation of Respondent's care of a nursing home patient after receiving a complaint.

4. The complaint arose over the amount of Dilantin that a patient had been prescribed by telephone order of Respondent after he had admitted the patient to St. Albans Health and Rehabilitation ("nursing home").

5. The patient had been admitted in the afternoon of May 10, 2012, from an inpatient hospital where she had recently undergone surgery to remove a brain tumor.

6. At the time of the patient's admission, Respondent saw and examined the patient, went over her history, surgery and medications and wrote orders for her care, including medications.

7. Sometime in the evening, Respondent received a telephone call from the patient's nurse at the nursing home telling him that she had discovered that the patient had been on Dilantin while hospitalized but it had erroneously been omitted from her nursing home orders. Respondent was concerned that he'd indeed omitted ordering an important medication, as Dilantin, an anti-seizure medication, is frequently prescribed after brain surgery.

8. Respondent told the nurse to write a telephone order for Dilantin.

9. The nurse inquired of Respondent what dosage the patient should be placed on, and Responded advised her to inquire of the referring hospital what dosage she had been on and start her on that.

10. The nurse later wrote down as a telephone order a dose of Dilantin for the patient and the patient was started on that dose; it is not clear from whom she obtained the dosing information but she did not call the Respondent back to discuss the amount with him.

11. The next time the Respondent was at the nursing home signing telephone orders, on May 26, he had a lot of them to sign; one of them was the telephone order of May 10, 2012 for the Dilantin.

12. The Respondent signed the order without noting that the dosage was larger than he was accustomed to prescribing. Had the Respondent noticed the dosage he would

have called the patient's referring hospital or her inpatient attending to determine if the non-standard dose was intentional or a mistake.

13. On the same day that the Respondent signed the telephone order, the patient was transferred out of the nursing home to a hospital.

14. At the hospital the patient was found to have an excessive Dilantin level which was eventually corrected by adjustment of the dose.

CONCLUSIONS OF LAW

15. The Board may find "that failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct." 26 V.S.A. § 1354(b).

16. The Respondent agrees that the Board might determine that failure to confirm a dose of Dilantin with a nurse calling for a telephone order constitutes a failure to practice competently and is therefore unprofessional conduct.

17. Respondent agrees that the Board might determine that a failure to carefully review and sign telephone orders more frequently than 16 days after being issued constitutes a failure to practice competently and is therefore unprofessional conduct.

18. Respondent agrees that if the State were to file charges against him based on the above cited facts, it could satisfy its burden at a hearing and a finding adverse to him could be entered by the Board, pursuant to 26 V.S.A. § 1354(b).

19. Respondent agrees that the Board may enter as its facts and/or conclusions paragraphs one through 1-18 above, and further agrees that these are an adequate basis for the Board actions set forth herein. Any representation by Respondent herein is made solely for the purpose set forth in this agreement and Respondent specifically does not

concede, by virtue of agreeing to enter into this Stipulation and Consent Order and abide by its terms, that he failed to practice competently or conducted himself incompetently.

20. In the interest of Respondent's desire to fully and finally resolve the matter presently before the Board, he has determined that he shall enter into this Stipulation and Consent Order with the Board. Respondent enters no admission here, but in order to resolve this matter without further time, expense and uncertainty, he agrees that this resolution is acceptable and in the best interest of the parties.

21. Respondent acknowledges that he is voluntarily agreeing to this Stipulation and Consent Order. He acknowledges that he has had advice of counsel regarding this matter and in the review of this document.

22. Respondent agrees and understands that by executing this document he is waiving any right to challenge the jurisdiction and continuing jurisdiction of the Board in this matter, to be presented with a specification of charges and evidence, to cross examine witnesses, and offer evidence of his own to contest the State's allegations.

23. The parties agree that upon their execution of this Stipulation and Consent Order, and pursuant to the terms herein, the above-captioned matter shall be administratively closed by the Board. Thereafter the Board will take no further action as to this matter absent non-compliance with the terms and conditions of this document by Respondent.

24. This Stipulation and Consent Order is conditioned upon its acceptance by the Board. It the Board rejects any part of this document, the entire agreement will be considered void. Respondent agrees that if the Board does not accept this agreement in its current form, he shall not assert in any subsequent proceeding any claim of prejudice from any such prior consideration. If the Board rejects any part of this document, none of

its terms shall bind Respondent or constitute an admission of any of the facts of the alleged misconduct, it shall not be used against Respondent in any way, it shall be kept in strict confidence, and it shall be without prejudice in any future disciplinary preceding and the Board's final determination of any charge against Respondent.

25. Respondent acknowledges and understands that this Stipulation and Consent Order shall be a matter of public record, shall be entered in his permanent Board file, shall constitute an enforceable legal agreement, and may and shall be reported to other licensing authorities, including but not limited to the Federation of State Medical Boards Board Action Databank, the National Practitioner Data Bank, and the Healthcare Integrity and Protection Data Bank.

26. In exchange for the actions by the Board, as set forth herein, Respondent expressly agrees to be bound by all terms and conditions of this Stipulation and Consent Order.

27. The parties jointly agree that should the terms and conditions of this Stipulation and Consent Order be deemed acceptable by the Vermont Board of Medical Practice, the Board may enter an order implementing the terms and conditions herein.

ORDER

WHEREFORE, based upon the foregoing Finding of Fact, Conclusions of Law, and the consent of Respondent, it is hereby ORDERED that:

a. Respondent will hereafter review and sign all telephone orders made by him to a nursing home where he sees patients within ten (10) days of their being issued. This provision applies whether the order is for a new medication or is merely an alteration of the dose of an on-going medication.

b. Before signing of any such telephone orders, Respondent will substantively review all such orders to make sure that they are in accordance with the patient's needs and contain what was orally transmitted by telephone.

c. In making any telephone order to a nursing home, the precise dosage will be discussed between Respondent and the nurse or other on-premises provider and agreed upon before the order will be executed.

d. Respondent shall pay an administrative penalty of $1,000.00 to the Board within thirty days of the entry of this Order.

e. Respondent is hereby reprimanded for the conduct set forth herein.

Dated at Montpelier, Vermont, this 23rd day of September, 2013.

STATE OF VERMONT

WILLIAM H. SORRELL
ATTORNEY GENERAL

by: _____

Kurt A. Kuehl
Assistant Attorney General
Vermont Attorney General's Office
109 State Street
Montpelier, VT 05609-1001

Dated at Fairfax, Vermont, this 16th day of September, 2013.

_____

TEIG D. MARCO, M.D.
Respondent

Dated at Burlington, Vermont, this 20 day of September, 2013.

S. Crocker Bennett, II, Esq.
Paul Frank + Collins P.C.
Counsel for Respondent

AS TO TEIG D. MARCO, M.D.
APPROVED AND ORDERED
VERMONT BOARD OF MEDICAL PRACTICE

Patricia A. King MD PhD

Wm H Stout MD

DATED: October 2, 2013

ENTERED AND EFFECTIVE: October 2, 2013

ATTACHMENT 2

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
RISK-BEARING PARTICIPANT & AFFILIATE (PREFERRED PROVIDER) AGREEMENT

Participant Name: Franklin County Rehab Center, LLC
Participant Address: 110 Fairfax Road
Saint Albans, VT 054786299
Participant TIN: 412052069

This RISK-BEARING PARTICIPANT / AFFILIATE AGREEMENT (the "Agreement") is by and between OneCare Vermont Accountable Care Organization, LLC ("ACO"), a Vermont limited liability company, and Participant or Affiliate, a health care provider or organization eligible to participate with ACO as defined below and organized under Vermont or New Hampshire law (collectively, the "Parties") and is effective the date signed by the ACO.

WHEREAS, ACO is an accountable care organization that intends to participate in alternative payment programs ("ACO Programs") with governmental and private payers (collectively referred to as "Payers ") and to conduct ACO Activities, as that term is defined below; and

WHEREAS, Participant and Affiliate agree to participate in the ACO Programs identified herein and ACO, Participant and Affiliate are committed to being accountable for the quality, cost and overall care of the individuals aligned with or attributed to the ACO under each ACO Program and committed to implementing and following processes and procedures to support that accountability and to sharing in the financial benefits or risks that result from those efforts;

WHEREAS, Participant, Affiliate and ACO understand that all ACO Programs made part of this Agreement require ACO and Participant to assume certain risk for the cost of care for Program Beneficiaries and is therefore considered and referred to as a "risk-bearing" arrangement;

NOW, THEREFORE, the Parties agree as follows:

1.0 DEFINITIONS

For purposes of this Agreement, the following terms shall have the meanings indicated. These definitions apply to the Agreement and all attachments, exhibits and ACO Program Addendums attached hereto. Any changes to the definitions under the ACO Program rules, regulations and laws will modify the following definitions as to that Program.

1.1 "ACO" means OneCare Vermont Accountable Care Organization, LLC, and more generally refers to a legal entity that is recognized and authorized under applicable State, Federal or Tribal law, is identified by a TIN, and is formed by one or more Providers that agree to work together to be accountable for the ACO Activities, as

established by the applicable ACO Program.

1.2 "ACO Activities" means activities related to promoting accountability for the quality, cost, and overall care for a patient population of beneficiaries aligned or attributed to the ACO under an ACO Program, including managing and coordinating care; encouraging investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and carrying out any other obligation or duty of the ACO under this Agreement. Additional examples of these activities include, but are not limited to, providing direct patient care to ACO Program Beneficiaries in a manner that reduces costs and improves quality; promoting evidence-based medicine and patient engagement; reporting on quality and cost measures under this Agreement; coordinating care for ACO Program Beneficiaries, such as through the use of telehealth, remote patient monitoring, and other enabling technologies; establishing and improving clinical and administrative systems for the ACO; meeting ACO Program performance standards by evaluating health needs of ACO Program Beneficiaries; communicating clinical knowledge and evidence-based medicine to ACO Program Beneficiaries; and developing standards for ACO Program Beneficiary access and communication, including ACO Program Beneficiary access to medical records.

1.3 "ACO Other Entity" means any entity that performs functions or services on behalf of an ACO or that works in collaboration with the ACO to accomplish ACO Activities, when that entity is not enrolled as a Participant or Affiliate. ACO Other Entities include, but are not limited to, contractors and consultants.

1.4 "ACO Policies" means generally ACO policies and procedures applicable to participation in ACO Programs. ACO Policies include, but are not limited to, privacy and security and data use policies, appeals policies, and the Clinical Model and its supporting policies.

1.5 "ACO Program" means a program between ACO and a Payer for population health management through an alternative payment arrangement or otherwise.

1.6 "ACO Program Addendum" means an addendum, attached hereto, that describes the program terms that govern the parties' obligations for that particular program.

1.7 "ACO Program Beneficiary" means an individual that receives healthcare benefits from a Payer in an ACO Program and is attributed or aligned to ACO.

1.8 "ACO Provider Portal" means the secure interface between ACO and Participant and Participant's Providers and Affiliates where ACO provides access to policies, procedures and other program information.

1.9 "Affiliate" or "Preferred Provider" means an individual or an entity that is: (1) identified by TIN; (2) included on the list of Preferred Providers submitted by ACO to Payers; and (3) that has entered into an Affiliate/Preferred Provider agreement with ACO to

participate in ACO Programs. Preferred Provider may be more particularly defined under each ACO Program, for example, as defined by the Medicare NextGen program, Affiliates do not align or attribute lives or quality report, but are eligible for participation in population based payments, coordinated care rewards and waiver programs such as telehealth, 3 day SNF stay and post discharge home visits.

1.10 "Clinical Model" means the written ACO guidelines, processes and procedures for quality and cost effectiveness founded on three inter-related and mutually supporting elements of: (1) quality performance measure management; (2) case management; and (3) clinical data sharing.

1.11 "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

1.12 "NPI" means the National Provider Identifier unique ten-digit identification number required for all licensed health care providers.

1.13 "OHCA" means an "organized health care arrangement" recognized under HIPAA that allows two or more Covered Entities who are clinically or operationally integrated, to share protected health information about their patients to manage and benefit their joint operations.

1.14 "Participant" means an individual or group of Providers that is: (1) identified by TIN; (2) included on any list of Participants submitted by ACO to Payers; and (3) that has entered into a participation agreement with ACO to participate in ACO Programs. Participant may be more particularly defined under each ACO Program.

1.15 "Payer" means the entity, which may be the ACO under certain ACO Programs, responsible for making financial payments or collecting Shared Risk under an ACO Program.

1.16 "Performance Year" means the twelve (12) month period measured by each ACO Program to determine financial reimbursement.

1.17 "Provider" means a health care practitioner or entity that: (1) meets the terms of participation in an ACO Program; (2) bills for items and services furnished to ACO Program Beneficiaries under a Participant or Preferred Provider's TIN; and (3) is included on the list of Participants or Preferred Providers submitted by ACO to Payers.

1.18 "Shared Risk" or "Shared Loss" is more particularly defined by each ACO Program but generally means the portion of ACO's Performance Year spending that was greater than expected spending and that must be returned to Payer.

1.19 "Shared Savings" is more particularly defined by each ACO Program, but generally

means the portion of ACO's Performance Year spending that was less than expected spending and that is paid to ACO by the Payer.

1.20 "TIN" means a Federal taxpayer identification number or employer identification number or social security number for providers who bill Payers under their social security numbers

2.0 ACO PROGRAM PARTICIPATION

2.1 Participation. Participants and Affiliates agree to be accountable for the quality, cost and overall care of ACO Program Beneficiaries by complying with the terms of this Agreement and following ACO Program rules and regulations, ACO Policies, and the Clinical Model. ACO will provide support services to Participants and Affiliates to facilitate efficient participation in the ACO Programs. Such support may include, but is not limited to, data reporting software and support, training, data analysis, data reporting and clinical leadership.

2.2 Qualification to Participate. Participant and Affiliate agree to participate in each ACO Program offered by a Payer for which Participant or Affiliate is an enrolled provider and in good standing. Participant, Providers and Affiliate Providers will maintain good standing to provide services under this Agreement with each Payer and will remain duly licensed in good standing to practice their professions in each state in which they practice. Any Participant who is eligible to align or attribute lives may only participate in one ACO Program per Payer, for example if an eligible aligning Participant is in Medicare NextGen, it may not be in MSSP. Nothing in this Agreement supersedes any of the terms and conditions of Participant's or Affiliate Provider's enrollment in a Payer's program. ACO, may, in its discretion, require additional reasonable verification of professional qualifications. Providers applying to be a Participant or Affiliate who do not meet the Clinical Model criteria, any ACO Program criteria, and Participants or Affiliates who are not renewed for any other reason will receive a written notice explaining the reason for denied participation status including instruction on how to appeal such denial to ACO.

2.3 Authority to Bind Employees. Participant and Affiliate represent and warrant that it has the authority, as an employer, to require its Providers and employees to comply with the applicable terms of this Agreement, ACO Program rules and regulations, and ACO Policies.

2.4 Management of Provider List. ACO retains the right to approve or disapprove new providers and to terminate or suspend Participants, Providers and Affiliates for cause, in accordance with the applicable ACO Program Addendums, Clinical Model or ACO Policies. Participant and Affiliates agree to manage their list of its participating Providers with ACO by providing timely notices of changes, as discussed in Section 8 below. To the extent that any Provider or employee identified by an NPI linked to

Participant's or Affiliate's TIN is excluded from an ACO Program, for any reason, disciplinary or otherwise, Participant or Affiliate will cooperate in de-linking or disassociating that Provider's NPI from the Participant's or Affiliate's TIN or ACO Program for purposes of billing applicable Payers.

2.5 Grievances and Appeals. Participants and Affiliates may submit grievances and appeal qualified ACO decisions in accordance with the ACO Appeals Policy, available on the ACO Provider Portal and incorporated herein by reference. To the extent an ACO Program dictates a specific appeals process that conflicts with the ACO Appeals Policy, the more restrictive policy shall apply.

2.6 Participation in ACO Governance. Participant and Affiliate agree to participate in aspects of the ACO's governance by participating in the election or appointment of the Participant and Affiliate representative(s) to ACO's Board of Managers and participating in the selection of member(s) of the Clinical Advisory Board and/or any sub-geographic or sub-specialty components of that Board.

3.0 PAYMENT

Payment terms shall be established in each applicable ACO Program Addendum.

4.0 TERM AND TERMINATION

4.1 Term. This Agreement shall commence on the Effective Date and continue until the earlier of: (1) when Participant or Affiliate is no longer participating in an ACO Program and (2) December 31, 2020. In the event that one ACO Program is terminated by ACO but others remain in effect, this Agreement shall continue to be effective as it pertains to the remaining ACO Programs. The termination provisions of each ACO Program Addendum shall govern a Participant's or Affiliate's term with respect to that ACO Program (the Effective Date of each ACO Program Addendum shall be the date on which it is executed by ACO).

4.2 Termination with Cause. Either Party may terminate this Agreement upon a material breach by the other Party by providing sixty (60) days' prior written notice to the Party alleged to be in breach identifying, with specificity, such breach, but only in the event that the alleged breaching Party fails to cure same within the sixty (60) day notice period. In the event an agreement under an ACO Program between ACO and the Payer terminates or in the event Participant or Affiliate terminates or non-renews an ACO Program Addendum, this Agreement shall only terminate with respect to those terminated or non-renewed ACO Programs and shall otherwise remain in full force and effect. In the event Participant or Affiliate terminates or non-renews all ACO Program Addenda, this Agreement shall also terminate. ACO Program obligations, such as quality reporting and obligations for Shared Risk may survive termination as set forth in ACO Program Addendum.

5.0 NOTICES

5.1 Required Notices. In addition to such disclosures as may be required in an ACO Program Addendum, Participant and Affiliate shall notify ACO and ACO shall notify Participant and Affiliate, in writing, as provided below. To the extent a notice requirement in an ACO Program Addendum conflicts with or is more stringent than the notice requirements below, the shorter of the timeframes shall apply.

5.2 Immediate Notices.

5.2.1 ACO shall provide Participant and Affiliate with immediate written notice of the termination of ACO's participation in an ACO Program under this Agreement;

5.2.2 Participant and Affiliate shall provide ACO with immediate written notice in the event Participant, Affiliate or either's Provider is convicted of a fraud or felony, or suspended, barred or excluded from participation in a federal health care program (as defined in 42 U.S.C. § 1320a-7b(f)); and

5.2.3 Participant and Affiliate shall provide ACO with immediate written notice in the event Participant or Affiliate receives a written notice of any cancellation, non-renewal or change to any insurance policy required under this Agreement.

5.3 Other Notices.

5.3.1 ACO shall, to the extent possible, provide Participant and Affiliate with thirty (30) days written notice prior to making any changes to terms applicable to ACO Programs, unless such changes are made to comply with a change in applicable law, addressed in more detail in Section 8.

5.3.2 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible but no later than thirty (30) days, in the event of a voluntary surrender or termination of any of Participant's, a Provider's or Affiliate's licenses, certifications, or accreditations;

5.3.3 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible after commencement of an investigation into conduct substantially related to the performance of this Agreement, by any law enforcement entity;

5.3.4 Participant and Affiliate shall provide ACO notice, as soon as reasonably possible after the occurrence of an act of nature or any event beyond Participant's or Affiliate's reasonable control which substantially interrupts all or a portion of Participant's or Affiliate's business or practice, or that has a materially adverse effect on Participant's or Affiliate's ability to perform its or his/her obligations hereunder; and

5.3.5 Participant and Affiliate shall provide ACO notice, as required by the applicable ACO Program Addendum, if any Provider becomes disassociated with Participant's or Affiliate's TIN for any reason.

6.0 RECORDS

6.1 Beneficiary and ACO Program Records. Participant and Affiliate shall prepare, maintain, and protect the confidentiality, security, accuracy, completeness and integrity of all appropriate medical and other records related to the provision of care to ACO Program Beneficiaries (including, but not limited to, medical, encounter, financial, accounting, administrative and billing records) in accordance with: (i) applicable state and federal laws and regulations including, but not limited to, applicable confidentiality requirements of the HIPAA; and (ii) ACO Program billing, reimbursement, and administrative requirements. Such records shall include such documentation as may be necessary to monitor and evaluate the quality of care and to conduct medical or other health care evaluations and audits to determine, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided.

6.2 Financial Records. Participant and Affiliate shall maintain such financial and accounting records as shall be necessary, appropriate or convenient for the proper administration of this Agreement, in accordance with generally accepted accounting principles or another acceptable basis of financial accounting, including, but not limited to, income-tax-basis financial statements, cash-basis or modified-cash-basis financial statements, or another basis that is otherwise generally accepted by the accounting industry.

6.3 Sharing Records. Participant and Affiliate acknowledge that by becoming a Participant or Affiliate it is agreeing to participate in an OHCA and further acknowledges that Beneficiary Records may be shared with other Participants or Affiliates for ACO Activities. In addition to OHCA sharing, Participant and Affiliate shall make the records available to and communicate as appropriate with each provider treating the ACO Program Beneficiary, as needed, for the purpose of facilitating the delivery of appropriate Health Care Services to each ACO Program Beneficiary. Subject to applicable laws regarding confidentiality, Participant, Affiliate and Providers hereby authorize ACO to release any and all information, records, summaries of records and statistical reports specific to Participants or Affiliate, including but not limited to utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Participant's or Affiliate's performance of services and professional qualifications to federal or state governmental authority(ies) with jurisdiction, or any of their authorized agents, and accreditation agencies, without receiving Participant's or Affiliate's prior consent.

6.4 Survival. The provisions of this section shall survive termination of this Agreement.

7.0 REPORTING AND MONITORING

7.1 Reporting. Participant and Affiliate shall report such data from its Electronic Health Records ("EHR") system or medical records as ACO may reasonably require to monitor the cost and quality of services, including care management services. By way of example and not limitation, ACO expects that it will require clinical data from electronic or paper health records, scheduling data, registration data, billing data, patient satisfaction survey data, and care management data. Participant will cooperate in connecting its information systems to ACO, or ACO's designee, in order to facilitate the exchange of clinical and cost related data in furtherance of the requirements of the applicable ACO Program. Participant and Affiliate each agree to enter into an agreement with Vermont Information Technology Leaders, or a successor health information exchange provider ("HIE"), to forward clinical information from Participant's or Affiliate's EHR to a third-party data repository designated by ACO, or any successor data repository, analytics, or case management system provider ("Data Repository"). Participant and Affiliate authorize ACO to direct HIE to forward clinical information to the Data Repository and authorizes Data Repository to de-identify protected health information sent by Participant and Affiliate, aggregate that de-identified data with other de-identified data and use the aggregated, de-identified data for Data Repository's data reporting, analytics purposes, and other data purposes. Participant and Affiliate authorize ACO to seek individually identifiable health information ("IIHI") regarding ACO Program Beneficiaries from any sources to be directed through the Data Repository for ACO purposes.

7.2 Monitoring. Subject to applicable confidentiality laws and within ten (10) business days following a request by ACO or an ACO Program Payer, Participant and Affiliate shall provide ACO, or its designees (which may include an independent auditor), access during regular business hours for: (i) inspection and copying of all records maintained by Participant or Affiliate related to Participant's or Affiliate provision of ACO Program covered services to ACO Program Beneficiaries (including, but not limited to, medical, financial, accounting, administrative and billing records); (ii) assessing the quality of care or investigating grievances and complaints of ACO Program Beneficiaries; and (iii) inspection of Participant's or Affiliate's facilities, policies and procedures for quality assurance, utilization review, verification of professional qualifications, claims payment verification, fraud and abuse investigation, financial policies, and other activities reasonably necessary for the efficient administration of the ACO, and as necessary for compliance with federal and state law or requirements. Participant and Affiliate also agree to cooperate with ACO's assessment of Participant's and Affiliate's qualifications to participate in risk-bearing ACO Programs.

7.3 Survival. The provisions of this Section 7 shall survive termination of the Agreement.

8.0 COMPLIANCE

8.1 ACO Program Rules, Clinical Model and ACO Policies. Participant and Affiliate agree to

support, comply with, and implement the Clinical Model and applicable ACO Program policies. Participant and Affiliate shall cooperate with ACO's case management protocols, which may include: placing in-office case managers at Participant's or Affiliate's practice; permitting ACO to conduct telephonic and on-site utilization management and quality assurance activities; and/or requiring Participant or Affiliate to coordinate with hospital or other facility case managers regarding the care of ACO Program Beneficiaries. Participant and Affiliate acknowledge that sharing of provider identifiable quality and cost data is a core component of ACO's Programs and consent to the sharing of such information. Participant and Affiliate shall implement such cost and quality control protocols or other interventions as may be adopted by ACO regarding the care of ACO Program Beneficiaries. ACO shall, to the extent practicable, make new policies available to Participants on the ACO Provider Portal prior to their implementation, unless those policies are changed to achieve regulatory or legal compliance for which immediate effectiveness is required. Participant and Affiliate also agree to participate in the ACO's compliance program including, but not limited to, participating in audits, attending compliance training, ensuring Participant's and Affiliate's policies are consistent or do not conflict with the ACO Program Rules, Clinical Model or ACO Policies, and educating Participant's and Affiliate's staff.

8.2 Applicable Law. Participant, Affiliate and ACO shall comply with all applicable laws and regulations governing participation with the ACO which include, but are not limited to, federal laws such as the False Claims Act, Anti-Kickback Laws, Civil Monetary Penalties Laws, Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Stark. Participant and Affiliate shall comply with the provisions set forth in the Business Associate and Qualified Service Organization Addendum, attached hereto as **Exhibit A**. Participant and Affiliate also agree to comply with the ACO Policies which are incorporated herein by reference and will be made available to Participant and Affiliate. Such compliance may include Participant and Affiliate compliance training.

8.3 Failure to Comply. Failure to comply with the terms of this Agreement or the applicable ACO Program Addendum may result in remedial processes and penalties which may include progressive discipline, including but not limited to, reductions of payment or termination of this Agreement as to Participant, Affiliate or a Provider.

9.0 CONFIDENTIALITY

9.1 Beneficiary Information. Beneficiary information, which may or may not include individually-identifiable protected health information, will be managed in accordance with ACO's HIPAA-compliant Privacy and Security Policy, ACO's Data Use Policy, and the Business Associate and Qualified Service Organization Addendum, attached hereto as **Exhibit A**.

9.2 Proprietary Information. The Parties each acknowledge that each may disclose confidential and proprietary information (by way of example and not limitation, policies

and procedures, records, formulas) to the other in the course of performance of this Agreement. All information so disclosed which is not otherwise publicly available shall be deemed confidential and shall not be further disclosed by the receiving Party without the prior written consent of the original disclosing Party. Upon termination of this Agreement, for any reason, each party shall return to the other all electronic and printed materials containing confidential or proprietary information received from the other, that it is not required to retain pursuant to this Agreement or law or certify to the other that those materials have been destroyed.

9.3 Survival. The obligations of this section 9 shall survive termination of this Agreement for any reason.

10.0 INSURANCE

10.1 Professional Insurance. Participant or Affiliate who is not a hospital or ambulatory service center or a Federally Qualified Health Center enjoying the privileges of Federal Tort Claim Act immunity, at its sole cost and expense, shall procure and maintain such professional liability insurance as is necessary to insure Participant, Affiliate and each of its respective Providers, employees, agents and representatives with coverage limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in annual aggregate in the performance of any act relating to this Agreement. Upon request, Participant, Affiliate or Provider, as appropriate, agree to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such professional liability policy is a "claims made" policy, Participant or Affiliate will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Participant and Affiliate agree to provide ACO with immediate written notice of any cancellation, non-renewal or change to such policy.

10.2 Hospital Insurance. Participant who is a hospital or ambulatory service center, at its sole cost and expense, shall procure and maintain such policies of insurance as are necessary to insure Participant and its Providers, employees, agents and representatives with coverage limits of not less than one million dollars ($1,000,000) per occurrence, three million dollars ($3,000,000) in annual aggregate, and five million dollars ($5,000,000) excess coverage in the performance of any act relating to this Agreement. Upon request, Participant agrees to submit to ACO a certificate of insurance as evidence of such coverage. In the event any such liability policy is a "claims made" policy, Participant will purchase a "tail" policy, effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior

acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available.

11.0 INDEMNIFICATION

Unless prohibited by Federal Tort Claim immunity or other law(s), Participant and Affiliate, on behalf of itself and its Providers, shall indemnify, defend and hold harmless ACO, its subsidiaries and affiliates and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the "ACO Parties") from and against any and all claims, suits, actions, liabilities, losses, injuries, damages, costs and expenses, interest, awards or judgments, incurred by ACO (including reasonable attorney's fees) in connection with the performance of this Agreement or any negligence or breach of the obligations and/or warranties of Participant or Preferred Provider, except to the extent the claims or losses are caused by the negligence or willful misconduct of ACO.

ACO shall defend, indemnify and hold harmless Participant or Affiliate, its subsidiaries and affiliates and each of their respective officers, directors, agents, representatives, successors, assigns and employees (the "Participant Party/ies") from and against any and all claims and losses incurred by Participant Party/ies as a result of any claim made by a third party against Participant Party/ies to the extent arising out of or relating to the ACO's negligence or breach of its obligations, representations or warranties set forth in this Agreement, except to the extent such claims or losses are caused by or result from the negligence of willful misconduct of any Participant Party.

If any claim or action is asserted that would entitle a Party to indemnification, the Parties shall give written notice thereof to the indemnifying party promptly; provided however, that the failure of the Party seeking indemnification to give timely notice hereunder shall not affect rights to indemnification hereunder, except to the extent that the indemnifying party is materially prejudiced by such failure. The indemnifying party shall have sole control over the defense of the claim, provided that the indemnifying party shall not settle, or make any admission of liability or guilt without first obtaining the Indemnified Party's written consent which consent shall not be unreasonably withheld or delayed. The obligation of this Indemnification provision shall survive expiration or termination of the Agreement.

12.0 GENERAL PROVISIONS

12.1 Entire Agreement. This Agreement, including exhibits, ACO Program Addendums or other attachments as well as any documents incorporated by reference, constitute the entire agreement between the Parties regarding participation in ACO Programs and supersedes any agreements prior its execution.

12.2 Successors and Assigns. This Agreement shall not be assigned by either Party without

the written consent of the other Party, which consent shall not be unreasonably withheld, provided that ACO may assign its rights and obligations under the Agreement to an entity that it controls or is controlled by or is under common control with ACO.

12.3 Amendments. This Agreement may be amended or modified in writing as mutually agreed upon by the Parties, or as provided in this Agreement. In addition, ACO may unilaterally modify any provision of this Agreement and its exhibits, addendums or attachments upon thirty (30) days prior written notice to Participant or as required in Section 8 to comply with federal or state laws or regulations.

12.4 Independent Contractor Relationship. None of the provisions of this Agreement between or among ACO, Participant, Affiliate, Providers, or Payers is intended to create a relationship other than that of an independent contractor relationship.

12.5 No Third-Party Beneficiaries. Except as specifically provided herein by express language, no person or entity shall have any rights, claims, benefits, or powers under this Agreement, and this Agreement shall not be construed or interpreted to confer any rights, claims, benefits or powers upon any third party.

12.6 Section Headings. All Section headings contained herein are for convenience and are not intended to limit, define or extend the scope of any provisions of this Agreement.

12.7 Severability. In the event any part of this Agreement shall be determined to be invalid, illegal or unenforceable under any federal or state law or regulation, or declared null and void by any court of competent jurisdiction, then such part shall be reformed, if possible, to conform with the law and, in any event, the remaining parts of this Agreement shall be fully effective and operative so far as reasonably possible to carry out the contractual purposes and terms set forth herein.

12.8 Waiver of Breach. The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach or violation of this Agreement.

12.9 Notices. Notices and other communications required by this Agreement shall be deemed to have been properly given if mailed by first-class mail, postage prepaid, or hand delivered to the following address:

ACO: OneCare Vermont Accountable Care Organization, LLC
356 Mountain View Drive, Suite 301, Colchester, VT 05446
Attn: Director of ACO Program Strategy and Network Development

Participant/Affiliate: Address located on title page of this Agreement

12.10 Counterparts, Signatures: This Agreement may be executed in multiple counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Any signature delivered by facsimile machine, or by .pdf, .tif, .gif, .peg or other similar attachment shall be treated in all manner and respects as an original executed counterpart and shall be considered to have the same binding legal effect as if it were the original signed version thereof delivered in person.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated above.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/AFFILIATE

By: Coleen Kohaut Date: 10/21/2016
Authorized Signature

Print Name: Coleen Kohaut
Title: Owner
Legal Business Name: Franklin County Rehab Center, LLC
TIN: 412052069

emailed to
aconetworkoperations@
onecarevt.org
10/21/16 (V2)

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC
DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL
ACO PROGRAM ADDENDUM

THIS DEPARTMENT OF VERMONT HEALTH ACCESS MEDICAID NEXT GENERATION MODEL ACO PROGRAM ADDEDNUM ("ACO Program Addendum") is attached to and made part of the Risk Bearing Participant and Affiliate Agreement ("Participant Agreement") in place between ACO and Participant or Affiliate (collectively, the "Parties"). To the extent any terms of this ACO Program Addendum conflict with terms of the Participant Agreement, the applicable terms of this ACO Program Addendum shall control. The ACO Program Agreement or policies from Vermont Medicaid applicable to the Participant or Affiliate shall control in the event of any conflict with the contractual provisions between ACO and Participant or Affiliate. To the extent any of the terms of this ACO Program Addendum conflict with the Department of Vermont Health Access ("DVHA") General Provider Agreement (between the Participant or Affiliate and DVHA), the DVHA General Provider Agreement shall control.

BACKGROUND

ACO has entered into an agreement with DVHA through which the ACO will participate in the Vermont Medicaid Next Generation Model (the "Program"), an alternative payment and population health management program with Medicaid, as described in the agreement between ACO and DVHA ("Vermont Medicaid Next Generation Participation Agreement" or "Participation Agreement") available on the ACO Secure Provider Portal and incorporated by reference into this ACO Program Addendum. ACO, Participant and Affiliate agree to participate in the Program as provided herein and are committed to performing ACO Activities, as that term is defined in the Participant Agreement.

NOW, THEREFORE, the Parties agree as follows:

1.0 MEDICAID NEXT GENERATION ACO PROGRAM PARTICIPATION

1.1 Participation. Participant and Affiliate agree to participate in the Program, to engage in ACO Activities, to comply with the applicable terms of the Program as set forth in the Vermont Medicaid Next Generation Participation Agreement between ACO and DVHA and to comply with all applicable laws and regulations. This compliance includes, but is not limited to, compliance with the provisions of the Vermont Medicaid Next Generation Participation Agreement relating to the following: (1) participant exclusivity; (2) quality measure reporting; (3) continuous care improvement objectives for Participants and Affiliates; (4) voluntary attribution; (5) Beneficiary freedom of choice; (6) benefit enhancements; (7) the coordinated care reward; (8) participation in evaluation, shared learning, monitoring and oversight activities; (9) the ACO Compliance Plan; (10) continuity of benefits and (11) audit and record retention requirements. Participant and Affiliate further agree that as part of their participation in the Program

and their Vermont Medicaid provider agreements that they will be prohibited from terminating a patient for any cause related to their health status or their need for medical services that result in health risk utilization of the Participant or Affiliate.

1.2 Updating Information. Participant and Affiliate are each required to update its Medicaid enrollment information (including the addition and deletion of Vermont Medicaid Next Generation Participants or providers, identified at the NPI level, that have reassigned to the Participant or Affiliate their right to Medicaid payment) on a timely basis in accordance with Medicaid program requirements.

1.3 Authority to Bind. Participant warrants that, in addition to the authority to bind providers under the Participant Agreement, it has the authority to and will bind each Next Generation Participant and provider, with an NPI number billing under the Participant's TIN and included on the Vermont Medicaid Next Generation Participant List approved by DVHA to the terms of this Program Addendum. Affiliate warrants that, in addition to the authority to bind providers under the Participation Agreement, it has the authority to and will bind each Provider with an NPI number and each employee whose services are billed under Affiliate's TIN.

1.4 Providers in Good Standing with Vermont and Medicaid. Participant agrees to require each provider whose NPI is associated with the Participant to maintain a current Vermont Medicaid provider agreement in good standing and to be duly licensed and remain in good standing with the appropriate state licensing board. Affiliate agrees to require each person performing services that are individually or collectively billed under Affiliate's TIN to be duly licensed and in good standing with the appropriate state licensing board and Vermont Medicaid and, as applicable, maintain a current Vermont Medicaid provider agreement. Participant and Affiliate shall maintain a current Vermont Medicaid provider agreement.

1.5 Contracting Exclusivity. Subject to the Program exclusivity requirements, ACO will not prohibit a Participant, Affiliate or provider from contracting with other state contractors.

1.6 Patient Record Requests. Participants and Affiliates will provide a Beneficiary with a copy of his/her medical records at no charge upon request by the Beneficiary, and facilitate the transfer of Beneficiary's medical record to another provider at Beneficiary's request.

1.7 Required Notices. Participants and Affiliates will provide ACO with the following notices:

1.7.1 All relevant information about any changes to Medicaid enrollment information, within thirty (30) days after the change.

1.7.2 All relevant information about any investigation sanctioned by the Government

or any licensing authority (including, without limitation, the imposition of program exclusion, debarment, civil monetary penalties, corrective action plans, and revocation of Medicaid billing privileges) within seven (7) days of becoming aware of the triggering event.

1.8 Exclusivity. Participants whose TIN includes NPIs of a Primary Care Practitioner (as determined by the Participation Agreement, but generally physician, physician assistant, or nurse practitioner designated as general practice, family medicine, internal medicine or geriatric medicine) who bills Qualified Evaluation and Management Services (as determined by the Participation Agreement and including evaluation and management codes) may not participate in more than one Medicaid Next Generation Model Program, or any other payment reform program in which they attribute or align lives, with another accountable care organization. Nothing in this paragraph shall be interpreted to preclude Participants, whose TIN does not include NPIs of Primary Care Practitioners, from membership in more than one accountable care organization participating in the Program. These exclusivity provisions are based on the Program rules and are subject to change if the Program rules change.

2.0 PAYMENT

2.1 Form of Payment. Affiliate will be paid fee-for-service. Before the beginning of each Performance Year, ACO will develop a program of payment for Participants. Participation in ACO may result in a change to the methodology or level of payment for delivering services to Beneficiaries whether payment is made by ACO, Medicaid, a combination of the two, or ACO's delegate. All payment methodologies and formulas will be made pursuant to a program of payment approved by the Board of Managers after receiving the necessary Program financial information from DVHA. The Board of Managers reserves the right to amend or alter payment methodology during the term of this Agreement.

a. Annually, before the required decision to participate for the Performance year, each non fee-for-service Participant will be provided, in writing, a description of the payment methodology and preliminary model of payment that is specific for the individual Participant. As soon as practical prior to the first day of a Performance Year, the Board of Managers will approve a final budget and program of payments for Participants and a final payment model will be issued to each Participant based on the information available from Payer. The Board of Managers reserves the right to adjust, amend or alter the final payment model as appropriate if the ACO financial model is changed, DVHA changes its commitment or for other reasons.

2.2 Payment in Full. Participant and Affiliate will collect applicable copayments, coinsurance and/or deductibles from Beneficiaries in accordance with their Medicaid benefits which are not affected by this ACO Program and agree to accept any applicable copayment,

coinsurance and/or deductible together with the payments provided for under this Agreement as full reimbursement for services rendered.

2.3 Claims Submission. Participants and Affiliates will submit claims to DVHA in accordance with timely filing rules and in accordance with DVHA's applicable policies, but will receive reimbursement for services within the Program, as outlined in this Section 2.0.

2.4 Services Outside the Program. The following services are excluded by DVHA from Program payments, and will be excluded from the payments by ACO and will be reimbursed by DVHA directly to Participants:

2.4.1 Services Not Covered in the Program. The following services are paid for by DVHA but are not included in the Program:

2.4.1.1 Pharmacy;
2.4.1.2 Nursing Facility Care;
2.4.1.3 Psychiatric Treatment in State Psychiatric Hospital;
2.4.1.4 Level 1 (involuntary placement) Inpatient Psychiatric Stays (in any hospital when paid for by DVHA);
2.4.1.5 Dental Services;
2.4.1.6 Non-emergency Transportation (ambulance transportation not included);
2.4.1.7 Smoking Cessation Services.

2.4.2 Other Services Not Covered. Other services offered to Beneficiaries but paid for by Vermont government departments other than DVHA are not covered in the program. This includes, but is not limited to, the following services:

2.4.2.1 Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by agencies other than DVHA;
2.4.2.2 Other services administered and paid for by the Vermont Department of Mental Health;
2.4.2.3 Services administered and paid for by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network;
2.4.2.4 Services administered by the Vermont Department of Disabilities, Aging and Independent Living;
2.4.2.5 Services administered and paid for by the Vermont Agency of Education;
2.4.2.6 Services administered and paid for by the Vermont Department of Health, including smoking cessation services.

2.5 Appeals and/or Grievances. Beneficiaries retain their rights to appeal claims determinations in accordance with the terms of the DVHA Member Handbook and Participants and Affiliates remain bound by the terms of the DVHA General Provider Agreement as to Beneficiary grievances and appeals. Participant and Affiliate will direct

all appeals and/or grievances or payment disputes to ACO and ACO will manage them in accordance with an ACO appeals policy that complies with Program requirements. The appeals policy includes a written initial appeal, and a second level of appeal with the opportunity to be heard in person. Participant and Affiliate will continue to cooperate with DVHA in the resolution of Beneficiary grievances and disputes.

2.6 Shared Savings. Shared Savings, if earned, will be contributed to a Value Base Incentive Pool which shall be distributed to Participants and/or Affiliates in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Savings during the term of this Agreement.

2.7 Shared Losses. Losses, if incurred, will be paid by ACO and Participants in a manner consistent with ACO strategy and approved by the Board of Managers. The Board of Managers may alter or amend the policies for Shared Losses during the term of this Agreement.

3.0 TERM, REMEDIAL ACTION AND TERMINATION

3.1 Term. The term of this Program Addendum shall commence on the Effective Date. The Initial Term shall be from the Effective Date through the last date of the fourth Performance Year for the Program, or December 31, 2020. Thereafter, this Agreement may be extended for additional one (1) year terms, as agreed by the Parties.

3.2 Remedial Action. ACO may take remedial action against the Participant or Affiliate including, but not limited to, imposition of a corrective action plan ("CAP"), reduction of payments, denied access to ACO data systems, and termination of the ACO's Participant Agreement or this Program Addendum with the Participant or Affiliate to address noncompliance with the terms of the Program or program integrity issues identified by ACO or CMS.

3.3 Termination. This Program Addendum will automatically terminate if the Participation Agreement terminates or if the Participant or Affiliate becomes ineligible to participate in Vermont Medicaid, for any reason. This Program Addendum will terminate prior to the end of the Initial Term or Term, as applicable, if DVHA requires the ACO to remove the Next Generation Participant from the approved list of providers, pursuant to the terms of the Next Generation Participation Agreement.

a. Participant may terminate this Agreement for Performance Year 2017 or non-renew for any subsequent Performance Year, if after receiving the applicable program of payment as approved by the Board of Managers it does not wish to participate, by providing written notice to ACO on or before September 1st of the year before the Performance Year commences (should DVHA provide additional time to ACO to provide a final list of participating providers, ACO will adjust that deadline as permitted by ACO Program). By

way of example, if Participant wishes to non-renew for Performance Year 2018, and ACO does not extend the deadline, notice must be given by September 1, 2017. If Participant terminates timely before Performance Year 2018, it shall have no obligations to ACO for that Performance Year. Should, Participant non-renew for any Performance Year after 2017, it will have no financial obligation to ACO for the Performance Year as to which it non-renewed, but must comply with Section 3.4.

b. ACO may terminate this ACO Program Addendum if, after evaluating the network of participants and the final financial terms for the ACO Program from DVHA, it determines not to participate in the ACO Program and provides that notice to DVHA in accordance with their deadline for ACOs to decline participation.

3.4 Close-Out, Performance Year Obligations. In the event this Program Addendum is terminated or expires, Participant and Affiliate agree to complete a close-out process by furnishing all quality measure reporting data, including all claims or encounters for services rendered to Beneficiaries, to ACO and to DVHA's fiscal agent. Moreover, Participant and Affiliate will be required to meet all financial obligations for the Performance Year of termination, including Shared Losses.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by the duly authorized officers to be effective as of the date executed by ACO indicated below.

ONECARE VERMONT ACCOUNTABLE CARE ORGANIZATION, LLC

By: _____ Date: _____
Todd B. Moore
Chief Executive Officer

PARTICIPANT/AFFILIATE

By: Coleen Kohaut Date: 10/21/2016
Authorized Signature

Print Name: Coleen Kohaut
Title: Owner
Legal Business Name: Franklin County Rehab Center, LLC
TIN: 412052069

ATTACHMENT 3

LICENSED ADMINISTRATOR
JOB DESCRIPTION

Job Purpose:

The primary purpose of the Licensed Administrator is to organize, develop and direct the overall operation of the facility in accordance with current federal, state, and local standards. The Licensed Administrator will direct and follow all guidelines, and regulations that govern the facility, and may be directed by the Medical Director, to make certain that the highest degree of quality care is maintained at all times.

Performance Standards:

- Takes initiative in identifying customer needs before the customer asks.
- Participates in teamwork willingly and with enthusiasm.
- Demonstrates respect for the dignity and privacy needs of customers through personal action and attention to the environment of care.
- Keeps customers informed, answers customer questions and anticipates information needs of customers.

Essential Job Functions:

- Facility Management
- Plan, develop, organize, implement, evaluate and direct the facility's programs and activities in conjunction with facility's operational budget and state and federal regulations.
- Lead the facility management staff and consultants in developing and working from a business plan that focuses on all aspects of facility operations, including setting priorities and job assignments.
- Monitor each department's activities, communicate policies, evaluate performance, provide feedback and assist, observe, coach, and discipline as needed.
- Develop an environment that allows for creative thinking, problem solving, and empowerment in the development of a facility management team.
- Oversee regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility, morale of the staff, and ensure resident needs are being addressed.
- Exhibit positive customer service both to internal and external customers.
- Utilize survey information, in addition to other source documents, to address areas of importance as defined by our customers.
- Verify that the building and grounds are maintained appropriately and that equipment and work areas are clean, safe, orderly, and any hazardous conditions are addressed.

Compliance Management:

- Maintain a working knowledge of and confirm compliance with all governmental regulations.
- Maintain facility staffing and retention requirements.
- Monitor Human Resources practices to verify compliance with employment laws and company policies.
- Confirm practices that maintain high morale and staff retention to include effective communication, prompt problem resolution, proactive supervisory practices and maintain a proactive work environment.
- Manage turnover and solidify current and future staffing through development of recruiting sources, and through appropriate selection, orientation, training, staff education and development.
- Assist in the recruitment and selection of competent department managers, supervisors, and other auxiliary personnel.
- Consult with department managers concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services.
- Provide disciplinary action and see that it is administered fairly and without regard to race, color, creed, national origin, age, sex, religion, disability, or marital status.
- Recognize staff for exceptional care and job performance on a regular basis and as part of their formal performance evaluation.

Business Management:

- Manage facility budgets and business practices to include labor costs, payables, and receivables.
- Monitor business activities to be certain procedures and standards are followed regarding appropriate handling of funds, and that sound credible business practices are followed at all times.
- Communicate budget guidelines and expectations to department managers.
- Manage marketing and revenue in regards to the business plan.
- Develop and implement a marketing strategy for the facility that reflects service opportunities, competition, potential market area changes; which maximizes census, payer mix, and ancillary revenues.
- Lead and monitor key staff and facility staff to play an active role in carrying out the marketing plan.
- Take initiative in evaluation, development and implementation of new business opportunities that meets the needs of the community and benefits the facility/company.
- Maintain positive community relations.
- Develop positive relationships on behalf of the Company with government regulators, residents, families, other area health care providers, physicians and the community at large.
- Act as a resource of information to the community related to health care issues.
- Attend or complete (CEUs) in-service education programs in order to meet facility and licensure educational requirements.
- Be familiar with Standard Precautions, Exposure Control Plan, Fire Drill and Evacuation Procedures and know how to use the information.
- Maintain confidentiality of resident and facility records/information.
- Protect residents from neglect, mistreatment, and abuse.
- Protect the personal property of the residents of the facility.
- Others duties as directed by the Director of Operations.

Franklin County
Rehab Center, LLC

ASSITANT ADMINISTRATOR

JOB DESCRIPTION

POSITION: ASSISTANT ADMINISTRATOR

The primary purpose of the Licensed Administrator is to assist the Administrator in organizing, development and directing the overall operation of facility operations in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to make certain that the highest degree of quality care is maintained at all times.
Requirements:

- ***Nursing Home Administrator license is required***
- Minimum of 2 years' Nursing Home Administrator experience in a skilled nursing facility
- Must have a proven track record of integrity and performance, and knowledge of the Long Term Care industry (customer satisfaction; employee satisfaction; regulatory compliance; clinical; financial)
- Embrace the standards, values, and beliefs of the organization
- Excellent communication skills
- Excellent organizational skills
- Must exhibit sound judgment making skills, patience and compassion
- Strong analytic and business skills
- Be capable of maintaining effective working relationships with residents, family members, staff members and stakeholders
- Possess the flexibility to approach skilled nursing and long term care services through a hospitality based model
- Good computer skills

Essential Functions and Responsibilities of the Position: The Assistant Administrator will assist the Administrator with the following management duties:

- Monitoring of resident care and services to achieve quality outcomes and high customer satisfaction
- Census management
- Staffing development goals
- Financial performance and management of all business operations of the facility
- Annual budget, P&L analysis, and reviews, statistical and financial reports
- Monitoring and maintenance of accurate medical records for billing, auditing, and regulatory compliance within approved company guidelines
- Managing and monitoring all departments for regulatory compliance
- Monitor and evaluate programs to promote the recruitment, retention, career development and continuing education of staff
- Develop, monitor and evaluate long range marketing and community outreach program
- Organize and direct committees and meetings per company policies

Job Description

Job Title: Payroll Clerk

Position Type: Administrative

Full or Part time: Full – (Mon – Thur)

Purpose: Oversee the payroll process for Franklin County Rehab Center

MAJOR TASKS, DUTIES AND RESPONSIBILITIES

- Maintains payroll information by collecting, calculating, and entering data.
- Updates payroll records by entering changes in exemptions, insurance coverage, savings deductions, and job title and department/division transfers.
- Prepares reports by compiling summaries of earnings, taxes, deductions, leave, disability, and nontaxable wages.
- Prepares Overtime reports weekly, and distribute to Administrator and Asst. Administrator.
- Determines payroll liabilities by calculating employee federal and state income and social security taxes and employer's social security, unemployment, and workers compensation payments.
- Resolves payroll discrepancies by collecting and analyzing information.
- Provides payroll information by answering questions and requests.
- Maintains payroll operations by following policies and procedures; reporting needed changes.
- Maintains employee confidence and protects payroll operations by keeping information confidential.
- Contributes to team effort by accomplishing related results as needed.
- Processes payroll weekly for Franklin County Rehab, Holiday House, and the Villa Rehab Center.
- Reviews time cards for accuracy (shift, department, job classification)
- Reports any time card / personnel issues to supervisors (late/early punching, no lunch punching)
- Inputs new employees into the system
- Must order Name Badges in the following format.

  NAME, License (RN, LPN, LNA) Title Below Or NAME (Top) License (Bottom)

- Process background checks within 1 day from receiving them from HR Assistant
- New Hire Reporting (State of VT)
- Enrolls employees into health insurance plan
- Setup enrollment into the 401k program
- Posts signs regarding changes / availability to employee benefits
- Calls in taxes
- Post 401k to John Hancock weekly
- Reports payroll deductions to the business office manager weekly to be entered into the check book register
- Responsible to manage email throughout the day to ensure timely communication.
- Must maintain professional interaction with employees, and members of the community
- Answers Phone as a backup to Administrative Assistant
- Backup to Chief Financial Officer on any designated projects.
- Any other duties as assigned by Administration or Supervisor.
- Responsible for Year End Reporting and Audit as it relates to Payroll.
- Responsible for Quarterly Call – In, Tardiness Report, and distribute to Dept. Heads quarterly
- Responsible to keep desk orderly and confidential information kept covered
- Terminate Employees timely from AHT Software and AOD

Supervisor:

Jessica Goss, Business Office Manager
Kate Gladden, Assistant Administrator

Skills/Qualifications:

Associates Degree in Business or related
Strong Communication Skills
Strong Computer Skills
Strong attention to detail
High level of organization

_____ _____

Employee Supervisor

Job Description

Job Title: Business Office Manager

Position Type: Administrative

Full or Part time: Full

Purpose: Provide accounting services and financial oversight.

MAJOR TASKS, DUTIES AND RESPONSIBILITIES

- Oversee all accounts receivable to include:
  - Billing for all insurances
  - Maintaining the AR Aging
  - Checking benefits for new admissions
- Oversee accounts payable to include:
  - Manual and Electronic checkbook balances
  - Accurately code and input invoices
  - Pay invoices and maintain cash flow analysis
- Oversee the General Ledger to include monthly preparation and analysis of:
  - Trial Balance
  - Income Statement
  - Balance Sheet
- Deposit weekly and as needed all cash and checks to the bank.
- Provide budgets and financial data analysis.
- Prepare and file all quarterly forms.
- Prepare all documents as requested for annual audit and cost reports, and any follow up issues or questions that may arise.
- Update census forms; maintain an accurate resident count with the nursing department.
- Maintain patient savings and checking accounts.
- Provide managerial oversight of the Payroll position and Administrative Assistant position.
- Respond to requests for information, inquiries and provide assistance.
- Assist with answering the phone in a timely fashion with a proper greeting.

- Respond to voice or e-mail messages timely, send and receive faxes.
- Order business office supplies as required.
- Maintain personnel and personnel medical files, and file accurately the paperwork that goes in them.
- Compose written correspondence and materials; create and update department forms when requested.
- Manage incoming mail.
- Perform assigned responsibilities, duties and tasks according to established practices, procedures, techniques and standards in a safe manner and with minimal supervision.
- Conduct job responsibilities in accordance with the FCRC Code of Conduct, policies and procedures, applicable federal and state laws and applicable professional standards.
- Promotes adherence to FCRC's Code of Business Conduct.

Supervisor:

Kate Gladden, Assistant Administrator
Coleen Kohaut, Administrator

Skills/Qualifications:

Associates Degree in Business or related
Strong Communication Skills
Strong Computer Skills
Strong attention to detail
High level of organization

Employee

Supervisor

ATTACHMENT 4

FRANKLIN COUNTY REHAB CENTER, LLC
110 FAIRFAX ROAD
SAINT ALBANS, VT 05478
(802) 752-1600

Benefit Explanation
Ancillary Department

FULL BENEFITS

Health Insurance
Earned Time (may be used for time off or sold
Starts accruing from DOH, available after 6 months)
Life Insurance
AFLAC Insurance
Additional Insurance Packages
Employee Assistance Program
Salary Redistribution Policy
In-Service Training (salary, tuition, mileage)
Continuing Education Benefits
Credit Union Membership
Hep B Vaccination Program
Flu Vaccination Program
Direct Deposit
Turkey or Ham @ Christmas
Christmas Bonus
Holiday Dinner/Dance
Employee Recognition Program
Health Fair (for employee & family)
Extra Earned Time Gift
Discounted Employee Meals

PARTIAL BENEFITS

Employee Assistance Program
Modified Earned Time (Accrue up to 1
week a year, starts accruing after 6 months)
Salary Redistribution Program
In Service training (onsite only)
Credit union Membership
Hep B Vaccination
Flu Vaccination
Direct Deposit
Turkey or Ham @ Christmas
Holiday Dinner/Dance
Employee Recognition program
Health Fair (for employee & family)
Extra Earned Time Gift
Discounted Employee Meals

Per Diem Status and Benefits

A per diem staff member is an individual who works on an on call basis to cover call-ins, vacations, and or periods of staff member illness. They cannot have regular scheduled time on a weekly basis on the same shift or for more than four weeks without a review from Administration. If an individual transfers from per diem to a scheduled work status they would be considered a new employee on the first day of scheduled work. Benefits include: HEP B Vaccination, Flu Vaccination, Turkey or Ham at Christmas, Health Fair for Employees.

Salary Adjustments

*Per Diem Benefit - $2.00 / Hour to Wage

ATTENTION ALL FCRC HEALTH INSURANCE PARTICIPANTS

BLUE CROSS/ BLUE SHIELD WILL BE OUR HEALTH INSURANCE CARRIER IN 2016. I have summarized the plan options below. If you have any questions please feel free to see me, or Sara Tibbits in the Business Office.

Thanks, Kate.

HMO – (STANDARD PLATINUM PLAN)

Single Person Plan $60.65 / week
2 Person Plan $212.30 / week
Adult + Kid(s) $201.69 / week
Family Plan $335.13 / week

- $150.00 deductible for single person plan / $300.00 deductible for 2 person or family plan (you pay this first before BCBS pays anything). After you meet the deductible you pay a 10% co-insurance on your medical bills until you reach an out of pocket max of $1,250.00 for single person plan / $2,500.00 for 2 person or family plan.

- $10.00 co-pay for a visit with your primary care physician
  $20.00 co-pay for a visit with a specialist

- $5.00 for generic, $40.00 preferred brand, 50% co-insurance for non-preferred brand. You have an out of pocket max of $1,250.00 for single person plan / $2,500.00 for 2 person or family plan for prescriptions.

HSA – (STANDARD CDHP PLANS / AGGREGATE DEDUCTIBLES)

Single Person Plan $17.30 / week
2 Person Plan $118.01 / week
Adult + Kid(s) $118.01 / week
Family Plan $118.01 / week

- $1,425.00 deductible for single person plan / $2850.00 deductible for 2 person or family plan (you pay this first before BCBS pays anything). After you meet the deductible you pay a 10% co-insurance on all BCBS bills until you reach an out of pocket max of $5,750.00 for single person plan / $11,500.00 for 2 person or family plan.

If you would like to change the plan you are currently on you must see Sara in payroll by December 21, 2015.

If you would like to join our Health Insurance Plan you must see Sara in payroll by November 23, 2015.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Sara Tibbits - Payroll.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Franklin County Rehab Center, LLC	41-2052069
5. Employer address	**6. Employer phone number**
110 Fairfax Road	802-752-1600

7. City	8. State	9. ZIP code
Saint Albans	VT	05478

10. Who can we contact about employee health coverage at this job?	
Sara Tibbits- Payroll	
11. Phone number (if different from above)	**12. Email address**
	stibbits@franklincountyrehab.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  Full Benefit
  ≥ 17 hours/week

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  spouse
  partner
  children

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? 1 full mo of work (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 17.30
b. How often? ☒ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

PREMIER

CONTRACTED SUPPLIER

Important information about your employee discount.

Premier Healthcare Alliance and Verizon Wireless have a new master wireless agreement.

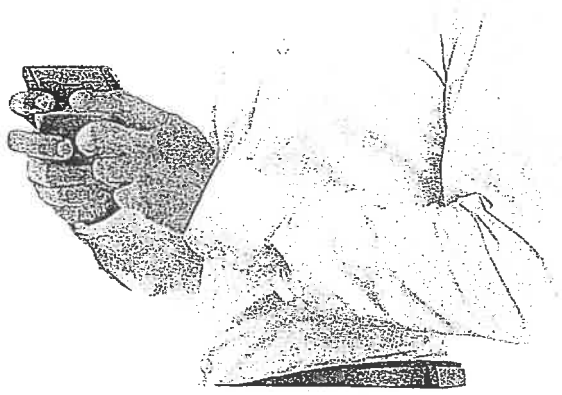
With the new agreement for healthcare companies, Verizon Wireless services will now be 19%. You can earn an additional 3% discount bringing your total discount to 22% by simply registering for My Verizon and enrolling in Paperless Billing.

Steps to receive a higher employee discount from Verizon Wireless:

To register for My Verizon please go to: www.verizonwireless.com. At the top of the page you will see where to Sign In or Register.

How to set up paperless billing:

1. Sign in to *My Verizon*.
2. Mouse over My Billing & Usage
3. Select Paperless Billing
4. At this point you can edit your email and text alerts if necessary.
5. Click Continue
6. You will see a confirmation, "Thank You for Enrolling in Paperless Billing"



For more information, contact your Verizon Wireless Business Specialist.

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verizon

PREMIER

SAVE ON WIRELESS SERVICES.

Premier Healthcare Members are eligible to receive the following discounts with Verizon Wireless, America's Largest 4G LTE Network, for wireless service lines:

CORPORATE LIABLE ONLY:

- 22% discount on Verizon Wireless monthly access fees*
- Quarterly Bill Incentive Credit (BIC) promotions up to $100 on select devices
  When you new 2 year agmt on $34.99 or higher calling plan or Share Everything plan with $34.99 or higher monthly account access fee, limited time offer
- $20 Corporate Custom 4G/3G Email Feature includes 3 GB. Overage rate $10/GB.
- $25/3GB Corporate Custom, Overage rate 3GB SHARE Feature, Overage is $15/GB
- $30/5GB Corporate Custom 4G Business Email Feature includes Mobile Hotspot. Overage rate is $10/GB
  All new 2 year agmts required. Available on eligible plans starting at $34.99 or higher.
- Waived activation fees
- 35% accessory discount**
- 500 text message package at no additional cost
  Standard rates apply to picture/video messages; $0.20 per message sent or received after allowance
- 1,000 domestic Text, Picture and Video Messages for $7.50
- Unlimited domestic Text, Picture and Video Messages for $15.00
- Other custom pricing offers unique to Premier members
  See your Verizon Wireless Business Specialist for more information.

Bill Incentive Credit up to $100 for bulk orders. Ask your Business Representative for details.

EMPLOYEE LIABLE ONLY:

- 25% accessory discount**
- 250 text message package at no additional cost
  Text only, no PIX messages. Standard rates apply to picture/video messages; $0.20 per message sent or received after allowance.
- 19% discount on Verizon Wireless monthly access fees with the ability to receive a 3% bonus discount by enrolling in "My Verizon" and paperless billing.

With easy, online account management and ordering, Verizon Wireless gives you the convenience and service you need.

Please contact your Verizon Wireless business representative for more information on additional benefits.

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* 2 year agmt required on eligible calling plans, unless customer specifically chooses, as are not applicable. On Share Everything plans, discount applies only to the monthly account access fee.
** Excludes Apple & manufacturer accessories.
Other Surcharges (Fed. Univ. Svc. of 15.0% of Interstate & Int'l network charges (varies quarterly), TRS, Regulatory & 911 Administrative/Maintenance, & others as applicable) are in addition to monthly access & not taxes (details: 1-888-684-1888; gov't taxes & other surcharges vary; ex: 6% - 42% in your HQ). Additional upgrade fee/line: Up to $35
IMPORTANT CONSUMER INFORMATION: Subject to Verizon Wireless Customer Agreement, Calling Plans, and credit approval. Up to $175 early termination fee/line ($350 for advanced devices & $15/GB rate after allowance). Network details & coverage maps at vzw.com.
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we give you credit

For your service, get credits on our service.

For all you do in your line of work, let us serve you every day with reliable AT&T wireless service. Surf the Web and talk at the same time. Enjoy the best global coverage of any U.S. carrier. Access thousands of apps. Expect even more. You deserve it.

Take credit now.
Order online today and enjoy your discount.

Company Name: Enter Facility Name

FAN Discount Code: Enter FAN

To receive your discount, visit: www.att.com/wireless/premiergpo

This offer available to members of

PREMIER
CONTRACTED SUPPLIER

Rethink Possible

IMPORTANT INFORMATION: [illegible] **Early Termination Fee** [illegible] **Other Monthly Charges** [illegible] **Monthly discount.** [illegible] **Limited-time offer.** [illegible] **Data** [illegible]

ATTACHMENT 5

Tressa Trust loan

Compound Period ..... : Monthly

Nominal Annual Rate .... : 4.000 %

CASH FLOW DATA

	Event	Date	Amount	Number	Period	End Date
1	Loan	12/31/2017	673,901.00	1		
2	Payment	01/31/2018	4,984.76	180	Monthly	12/31/2032

AMORTIZATION SCHEDULE - Normal Amortization

	Date	Payment	Interest	Principal	Balance
Loan	12/31/2017				673,901.00
2017 Totals		0.00	0.00	0.00	
1	01/31/2018	4,984.76	2,246.34	2,738.42	671,162.58
2	02/28/2018	4,984.76	2,237.21	2,747.55	668,415.03
3	03/31/2018	4,984.76	2,228.05	2,756.71	665,658.32
4	04/30/2018	4,984.76	2,218.86	2,765.90	662,892.42
5	05/31/2018	4,984.76	2,209.64	2,775.12	660,117.30
6	06/30/2018	4,984.76	2,200.39	2,784.37	657,332.93
7	07/31/2018	4,984.76	2,191.11	2,793.65	654,539.28
8	08/31/2018	4,984.76	2,181.80	2,802.96	651,736.32
9	09/30/2018	4,984.76	2,172.45	2,812.31	648,924.01
10	10/31/2018	4,984.76	2,163.08	2,821.68	646,102.33
11	11/30/2018	4,984.76	2,153.67	2,831.09	643,271.24
12	12/31/2018	4,984.76	2,144.24	2,840.52	640,430.72
2018 Totals		59,817.12	26,346.84	33,470.28	
13	01/31/2019	4,984.76	2,134.77	2,849.99	637,580.73
14	02/28/2019	4,984.76	2,125.27	2,859.49	634,721.24
15	03/31/2019	4,984.76	2,115.74	2,869.02	631,852.22
16	04/30/2019	4,984.76	2,106.17	2,878.59	628,973.63
17	05/31/2019	4,984.76	2,096.58	2,888.18	626,085.45
18	06/30/2019	4,984.76	2,086.95	2,897.81	623,187.64
19	07/31/2019	4,984.76	2,077.29	2,907.47	620,280.17
20	08/31/2019	4,984.76	2,067.60	2,917.16	617,363.01
21	09/30/2019	4,984.76	2,057.88	2,926.88	614,436.13
22	10/31/2019	4,984.76	2,048.12	2,936.64	611,499.49
23	11/30/2019	4,984.76	2,038.33	2,946.43	608,553.06
24	12/31/2019	4,984.76	2,028.51	2,956.25	605,596.81
2019 Totals		59,817.12	24,983.21	34,833.91	
25	01/31/2020	4,984.76	2,018.66	2,966.10	602,630.71
26	02/29/2020	4,984.76	2,008.77	2,975.99	599,654.72
27	03/31/2020	4,984.76	1,998.85	2,985.91	596,668.81
28	04/30/2020	4,984.76	1,988.90	2,995.86	593,672.95
29	05/31/2020	4,984.76	1,978.91	3,005.85	590,667.10

Tressa Trust loan

	Date	Payment	Interest	Principal	Balance
30	06/30/2020	4,984.76	1,968.89	3,015.87	587,651.23
31	07/31/2020	4,984.76	1,958.84	3,025.92	584,625.31
32	08/31/2020	4,984.76	1,948.75	3,036.01	581,589.30
33	09/30/2020	4,984.76	1,938.63	3,046.13	578,543.17
34	10/31/2020	4,984.76	1,928.48	3,056.28	575,486.89
35	11/30/2020	4,984.76	1,918.29	3,066.47	572,420.42
36	12/31/2020	4,984.76	1,908.07	3,076.69	569,343.73
2020 Totals		59,817.12	23,564.04	36,253.08	
37	01/31/2021	4,984.76	1,897.81	3,086.95	566,256.78
38	02/28/2021	4,984.76	1,887.52	3,097.24	563,159.54
39	03/31/2021	4,984.76	1,877.20	3,107.56	560,051.98
40	04/30/2021	4,984.76	1,866.84	3,117.92	556,934.06
41	05/31/2021	4,984.76	1,856.45	3,128.31	553,805.75
42	06/30/2021	4,984.76	1,846.02	3,138.74	550,667.01
43	07/31/2021	4,984.76	1,835.56	3,149.20	547,517.81
44	08/31/2021	4,984.76	1,825.06	3,159.70	544,358.11
45	09/30/2021	4,984.76	1,814.53	3,170.23	541,187.88
46	10/31/2021	4,984.76	1,803.96	3,180.80	538,007.08
47	11/30/2021	4,984.76	1,793.36	3,191.40	534,815.68
48	12/31/2021	4,984.76	1,782.72	3,202.04	531,613.64
2021 Totals		59,817.12	22,087.03	37,730.09	
49	01/31/2022	4,984.76	1,772.05	3,212.71	528,400.93
50	02/28/2022	4,984.76	1,761.34	3,223.42	525,177.51
51	03/31/2022	4,984.76	1,750.59	3,234.17	521,943.34
52	04/30/2022	4,984.76	1,739.81	3,244.95	518,698.39
53	05/31/2022	4,984.76	1,728.99	3,255.77	515,442.62
54	06/30/2022	4,984.76	1,718.14	3,266.62	512,176.00
55	07/31/2022	4,984.76	1,707.25	3,277.51	508,898.49
56	08/31/2022	4,984.76	1,696.33	3,288.43	505,610.06
57	09/30/2022	4,984.76	1,685.37	3,299.39	502,310.67
58	10/31/2022	4,984.76	1,674.37	3,310.39	499,000.28
59	11/30/2022	4,984.76	1,663.33	3,321.43	495,678.85
60	12/31/2022	4,984.76	1,652.26	3,332.50	492,346.35
2022 Totals		59,817.12	20,549.83	39,267.29	
61	01/31/2023	4,984.76	1,641.15	3,343.61	489,002.74
62	02/28/2023	4,984.76	1,630.01	3,354.75	485,647.99
63	03/31/2023	4,984.76	1,618.83	3,365.93	482,282.06
64	04/30/2023	4,984.76	1,607.61	3,377.15	478,904.91
65	05/31/2023	4,984.76	1,596.35	3,388.41	475,516.50
66	06/30/2023	4,984.76	1,585.06	3,399.70	472,116.80
67	07/31/2023	4,984.76	1,573.72	3,411.04	468,705.76
68	08/31/2023	4,984.76	1,562.35	3,422.41	465,283.35
69	09/30/2023	4,984.76	1,550.94	3,433.82	461,849.53
70	10/31/2023	4,984.76	1,539.50	3,445.26	458,404.27
71	11/30/2023	4,984.76	1,528.01	3,456.75	454,947.52
72	12/31/2023	4,984.76	1,516.49	3,468.27	451,479.25

Tressa Trust loan

	Date	Payment	Interest	Principal	Balance
2023 Totals		59,817.12	18,950.02	40,867.10	
73	01/31/2024	4,984.76	1,504.93	3,479.83	447,999.42
74	02/29/2024	4,984.76	1,493.33	3,491.43	444,507.99
75	03/31/2024	4,984.76	1,481.69	3,503.07	441,004.92
76	04/30/2024	4,984.76	1,470.02	3,514.74	437,490.18
77	05/31/2024	4,984.76	1,458.30	3,526.46	433,963.72
78	06/30/2024	4,984.76	1,446.55	3,538.21	430,425.51
79	07/31/2024	4,984.76	1,434.75	3,550.01	426,875.50
80	08/31/2024	4,984.76	1,422.92	3,561.84	423,313.66
81	09/30/2024	4,984.76	1,411.05	3,573.71	419,739.95
82	10/31/2024	4,984.76	1,399.13	3,585.63	416,154.32
83	11/30/2024	4,984.76	1,387.18	3,597.58	412,556.74
84	12/31/2024	4,984.76	1,375.19	3,609.57	408,947.17
2024 Totals		59,817.12	17,285.04	42,532.08	
85	01/31/2025	4,984.76	1,363.16	3,621.60	405,325.57
86	02/28/2025	4,984.76	1,351.09	3,633.67	401,691.90
87	03/31/2025	4,984.76	1,338.97	3,645.79	398,046.11
88	04/30/2025	4,984.76	1,326.82	3,657.94	394,388.17
89	05/31/2025	4,984.76	1,314.63	3,670.13	390,718.04
90	06/30/2025	4,984.76	1,302.39	3,682.37	387,035.67
91	07/31/2025	4,984.76	1,290.12	3,694.64	383,341.03
92	08/31/2025	4,984.76	1,277.80	3,706.96	379,634.07
93	09/30/2025	4,984.76	1,265.45	3,719.31	375,914.76
94	10/31/2025	4,984.76	1,253.05	3,731.71	372,183.05
95	11/30/2025	4,984.76	1,240.61	3,744.15	368,438.90
96	12/31/2025	4,984.76	1,228.13	3,756.63	364,682.27
2025 Totals		59,817.12	15,552.22	44,264.90	
97	01/31/2026	4,984.76	1,215.61	3,769.15	360,913.12
98	02/28/2026	4,984.76	1,203.04	3,781.72	357,131.40
99	03/31/2026	4,984.76	1,190.44	3,794.32	353,337.08
100	04/30/2026	4,984.76	1,177.79	3,806.97	349,530.11
101	05/31/2026	4,984.76	1,165.10	3,819.66	345,710.45
102	06/30/2026	4,984.76	1,152.37	3,832.39	341,878.06
103	07/31/2026	4,984.76	1,139.59	3,845.17	338,032.89
104	08/31/2026	4,984.76	1,126.78	3,857.98	334,174.91
105	09/30/2026	4,984.76	1,113.92	3,870.84	330,304.07
106	10/31/2026	4,984.76	1,101.01	3,883.75	326,420.32
107	11/30/2026	4,984.76	1,088.07	3,896.69	322,523.63
108	12/31/2026	4,984.76	1,075.08	3,909.68	318,613.95
2026 Totals		59,817.12	13,748.80	46,068.32	
109	01/31/2027	4,984.76	1,062.05	3,922.71	314,691.24
110	02/28/2027	4,984.76	1,048.97	3,935.79	310,755.45
111	03/31/2027	4,984.76	1,035.85	3,948.91	306,806.54
112	04/30/2027	4,984.76	1,022.69	3,962.07	302,844.47
113	05/31/2027	4,984.76	1,009.48	3,975.28	298,869.19

Tressa Trust loan

	Date	Payment	Interest	Principal	Balance
114	06/30/2027	4,984.76	996.23	3,988.53	294,880.66
115	07/31/2027	4,984.76	982.94	4,001.82	290,878.84
116	08/31/2027	4,984.76	969.60	4,015.16	286,863.68
117	09/30/2027	4,984.76	956.21	4,028.55	282,835.13
118	10/31/2027	4,984.76	942.78	4,041.98	278,793.15
119	11/30/2027	4,984.76	929.31	4,055.45	274,737.70
120	12/31/2027	4,984.76	915.79	4,068.97	270,668.73
2027 Totals		59,817.12	11,871.90	47,945.22	
121	01/31/2028	4,984.76	902.23	4,082.53	266,586.20
122	02/29/2028	4,984.76	888.62	4,096.14	262,490.06
123	03/31/2028	4,984.76	874.97	4,109.79	258,380.27
124	04/30/2028	4,984.76	861.27	4,123.49	254,256.78
125	05/31/2028	4,984.76	847.52	4,137.24	250,119.54
126	06/30/2028	4,984.76	833.73	4,151.03	245,968.51
127	07/31/2028	4,984.76	819.90	4,164.86	241,803.65
128	08/31/2028	4,984.76	806.01	4,178.75	237,624.90
129	09/30/2028	4,984.76	792.08	4,192.68	233,432.22
130	10/31/2028	4,984.76	778.11	4,206.65	229,225.57
131	11/30/2028	4,984.76	764.09	4,220.67	225,004.90
132	12/31/2028	4,984.76	750.02	4,234.74	220,770.16
2028 Totals		59,817.12	9,918.55	49,898.57	
133	01/31/2029	4,984.76	735.90	4,248.86	216,521.30
134	02/28/2029	4,984.76	721.74	4,263.02	212,258.28
135	03/31/2029	4,984.76	707.53	4,277.23	207,981.05
136	04/30/2029	4,984.76	693.27	4,291.49	203,689.56
137	05/31/2029	4,984.76	678.97	4,305.79	199,383.77
138	06/30/2029	4,984.76	664.61	4,320.15	195,063.62
139	07/31/2029	4,984.76	650.21	4,334.55	190,729.07
140	08/31/2029	4,984.76	635.76	4,349.00	186,380.07
141	09/30/2029	4,984.76	621.27	4,363.49	182,016.58
142	10/31/2029	4,984.76	606.72	4,378.04	177,638.54
143	11/30/2029	4,984.76	592.13	4,392.63	173,245.91
144	12/31/2029	4,984.76	577.49	4,407.27	168,838.64
2029 Totals		59,817.12	7,885.60	51,931.52	
145	01/31/2030	4,984.76	562.80	4,421.96	164,416.68
146	02/28/2030	4,984.76	548.06	4,436.70	159,979.98
147	03/31/2030	4,984.76	533.27	4,451.49	155,528.49
148	04/30/2030	4,984.76	518.43	4,466.33	151,062.16
149	05/31/2030	4,984.76	503.54	4,481.22	146,580.94
150	06/30/2030	4,984.76	488.60	4,496.16	142,084.78
151	07/31/2030	4,984.76	473.62	4,511.14	137,573.64
152	08/31/2030	4,984.76	458.58	4,526.18	133,047.46
153	09/30/2030	4,984.76	443.49	4,541.27	128,506.19
154	10/31/2030	4,984.76	428.35	4,556.41	123,949.78
155	11/30/2030	4,984.76	413.17	4,571.59	119,378.19
156	12/31/2030	4,984.76	397.93	4,586.83	114,791.36

Tressa Trust loan

	Date	Payment	Interest	Principal	Balance
2030 Totals		59,817.12	5,769.84	54,047.28	
157	01/31/2031	4,984.76	382.64	4,602.12	110,189.24
158	02/28/2031	4,984.76	367.30	4,617.46	105,571.78
159	03/31/2031	4,984.76	351.91	4,632.85	100,938.93
160	04/30/2031	4,984.76	336.46	4,648.30	96,290.63
161	05/31/2031	4,984.76	320.97	4,663.79	91,626.84
162	06/30/2031	4,984.76	305.42	4,679.34	86,947.50
163	07/31/2031	4,984.76	289.83	4,694.93	82,252.57
164	08/31/2031	4,984.76	274.18	4,710.58	77,541.99
165	09/30/2031	4,984.76	258.47	4,726.29	72,815.70
166	10/31/2031	4,984.76	242.72	4,742.04	68,073.66
167	11/30/2031	4,984.76	226.91	4,757.85	63,315.81
168	12/31/2031	4,984.76	211.05	4,773.71	58,542.10
2031 Totals		59,817.12	3,567.86	56,249.26	
169	01/31/2032	4,984.76	195.14	4,789.62	53,752.48
170	02/29/2032	4,984.76	179.17	4,805.59	48,946.89
171	03/31/2032	4,984.76	163.16	4,821.60	44,125.29
172	04/30/2032	4,984.76	147.08	4,837.68	39,287.61
173	05/31/2032	4,984.76	130.96	4,853.80	34,433.81
174	06/30/2032	4,984.76	114.78	4,869.98	29,563.83
175	07/31/2032	4,984.76	98.55	4,886.21	24,677.62
176	08/31/2032	4,984.76	82.26	4,902.50	19,775.12
177	09/30/2032	4,984.76	65.92	4,918.84	14,856.28
178	10/31/2032	4,984.76	49.52	4,935.24	9,921.04
179	11/30/2032	4,984.76	33.07	4,951.69	4,969.35
180	12/31/2032	4,984.76	15.41	4,969.35	0.00
2032 Totals		59,817.12	1,275.02	58,542.10	
Grand Totals		897,256.80	223,355.80	673,901.00	

Tressa Trust loan

Last interest amount decreased by 1.15 due to rounding.

Phil Loan

Compound Period ..... : Monthly

Nominal Annual Rate .... : 4.000 %

CASH FLOW DATA

	Event	Date	Amount	Number	Period	End Date
1	Loan	12/31/2017	794,746.96	1		
2	Payment	01/31/2018	5,878.65	180	Monthly	12/31/2032

AMORTIZATION SCHEDULE - Normal Amortization

	Date	Payment	Interest	Principal	Balance
Loan	12/31/2017				794,746.96
2017 Totals		0.00	0.00	0.00	
1	01/31/2018	5,878.65	2,649.16	3,229.49	791,517.47
2	02/28/2018	5,878.65	2,638.39	3,240.26	788,277.21
3	03/31/2018	5,878.65	2,627.59	3,251.06	785,026.15
4	04/30/2018	5,878.65	2,616.75	3,261.90	781,764.25
5	05/31/2018	5,878.65	2,605.88	3,272.77	778,491.48
6	06/30/2018	5,878.65	2,594.97	3,283.68	775,207.80
7	07/31/2018	5,878.65	2,584.03	3,294.62	771,913.18
8	08/31/2018	5,878.65	2,573.04	3,305.61	768,607.57
9	09/30/2018	5,878.65	2,562.03	3,316.62	765,290.95
10	10/31/2018	5,878.65	2,550.97	3,327.68	761,963.27
11	11/30/2018	5,878.65	2,539.88	3,338.77	758,624.50
12	12/31/2018	5,878.65	2,528.75	3,349.90	755,274.60
2018 Totals		70,543.80	31,071.44	39,472.36	
13	01/31/2019	5,878.65	2,517.58	3,361.07	751,913.53
14	02/28/2019	5,878.65	2,506.38	3,372.27	748,541.26
15	03/31/2019	5,878.65	2,495.14	3,383.51	745,157.75
16	04/30/2019	5,878.65	2,483.86	3,394.79	741,762.96
17	05/31/2019	5,878.65	2,472.54	3,406.11	738,356.85
18	06/30/2019	5,878.65	2,461.19	3,417.46	734,939.39
19	07/31/2019	5,878.65	2,449.80	3,428.85	731,510.54
20	08/31/2019	5,878.65	2,438.37	3,440.28	728,070.26
21	09/30/2019	5,878.65	2,426.90	3,451.75	724,618.51
22	10/31/2019	5,878.65	2,415.40	3,463.25	721,155.26
23	11/30/2019	5,878.65	2,403.85	3,474.80	717,680.46
24	12/31/2019	5,878.65	2,392.27	3,486.38	714,194.08
2019 Totals		70,543.80	29,463.28	41,080.52	
25	01/31/2020	5,878.65	2,380.65	3,498.00	710,696.08
26	02/29/2020	5,878.65	2,368.99	3,509.66	707,186.42
27	03/31/2020	5,878.65	2,357.29	3,521.36	703,665.06
28	04/30/2020	5,878.65	2,345.55	3,533.10	700,131.96
29	05/31/2020	5,878.65	2,333.77	3,544.88	696,587.08

Phil Loan

	Date	Payment	Interest	Principal	Balance
30	06/30/2020	5,878.65	2,321.96	3,556.69	693,030.39
31	07/31/2020	5,878.65	2,310.10	3,568.55	689,461.84
32	08/31/2020	5,878.65	2,298.21	3,580.44	685,881.40
33	09/30/2020	5,878.65	2,286.27	3,592.38	682,289.02
34	10/31/2020	5,878.65	2,274.30	3,604.35	678,684.67
35	11/30/2020	5,878.65	2,262.28	3,616.37	675,068.30
36	12/31/2020	5,878.65	2,250.23	3,628.42	671,439.88
2020 Totals		70,543.80	27,789.60	42,754.20	
37	01/31/2021	5,878.65	2,238.13	3,640.52	667,799.36
38	02/28/2021	5,878.65	2,226.00	3,652.65	664,146.71
39	03/31/2021	5,878.65	2,213.82	3,664.83	660,481.88
40	04/30/2021	5,878.65	2,201.61	3,677.04	656,804.84
41	05/31/2021	5,878.65	2,189.35	3,689.30	653,115.54
42	06/30/2021	5,878.65	2,177.05	3,701.60	649,413.94
43	07/31/2021	5,878.65	2,164.71	3,713.94	645,700.00
44	08/31/2021	5,878.65	2,152.33	3,726.32	641,973.68
45	09/30/2021	5,878.65	2,139.91	3,738.74	638,234.94
46	10/31/2021	5,878.65	2,127.45	3,751.20	634,483.74
47	11/30/2021	5,878.65	2,114.95	3,763.70	630,720.04
48	12/31/2021	5,878.65	2,102.40	3,776.25	626,943.79
2021 Totals		70,543.80	26,047.71	44,496.09	
49	01/31/2022	5,878.65	2,089.81	3,788.84	623,154.95
50	02/28/2022	5,878.65	2,077.18	3,801.47	619,353.48
51	03/31/2022	5,878.65	2,064.51	3,814.14	615,539.34
52	04/30/2022	5,878.65	2,051.80	3,826.85	611,712.49
53	05/31/2022	5,878.65	2,039.04	3,839.61	607,872.88
54	06/30/2022	5,878.65	2,026.24	3,852.41	604,020.47
55	07/31/2022	5,878.65	2,013.40	3,865.25	600,155.22
56	08/31/2022	5,878.65	2,000.52	3,878.13	596,277.09
57	09/30/2022	5,878.65	1,987.59	3,891.06	592,386.03
58	10/31/2022	5,878.65	1,974.62	3,904.03	588,482.00
59	11/30/2022	5,878.65	1,961.61	3,917.04	584,564.96
60	12/31/2022	5,878.65	1,948.55	3,930.10	580,634.86
2022 Totals		70,543.80	24,234.87	46,308.93	
61	01/31/2023	5,878.65	1,935.45	3,943.20	576,691.66
62	02/28/2023	5,878.65	1,922.31	3,956.34	572,735.32
63	03/31/2023	5,878.65	1,909.12	3,969.53	568,765.79
64	04/30/2023	5,878.65	1,895.89	3,982.76	564,783.03
65	05/31/2023	5,878.65	1,882.61	3,996.04	560,786.99
66	06/30/2023	5,878.65	1,869.29	4,009.36	556,777.63
67	07/31/2023	5,878.65	1,855.93	4,022.72	552,754.91
68	08/31/2023	5,878.65	1,842.52	4,036.13	548,718.78
69	09/30/2023	5,878.65	1,829.06	4,049.59	544,669.19
70	10/31/2023	5,878.65	1,815.56	4,063.09	540,606.10
71	11/30/2023	5,878.65	1,802.02	4,076.63	536,529.47
72	12/31/2023	5,878.65	1,788.43	4,090.22	532,439.25

Phil Loan

	Date	Payment	Interest	Principal	Balance
2023 Totals		70,543.80	22,348.19	48,195.61	
73	01/31/2024	5,878.65	1,774.80	4,103.85	528,335.40
74	02/29/2024	5,878.65	1,761.12	4,117.53	524,217.87
75	03/31/2024	5,878.65	1,747.39	4,131.26	520,086.61
76	04/30/2024	5,878.65	1,733.62	4,145.03	515,941.58
77	05/31/2024	5,878.65	1,719.81	4,158.84	511,782.74
78	06/30/2024	5,878.65	1,705.94	4,172.71	507,610.03
79	07/31/2024	5,878.65	1,692.03	4,186.62	503,423.41
80	08/31/2024	5,878.65	1,678.08	4,200.57	499,222.84
81	09/30/2024	5,878.65	1,664.08	4,214.57	495,008.27
82	10/31/2024	5,878.65	1,650.03	4,228.62	490,779.65
83	11/30/2024	5,878.65	1,635.93	4,242.72	486,536.93
84	12/31/2024	5,878.65	1,621.79	4,256.86	482,280.07
2024 Totals		70,543.80	20,384.62	50,159.18	
85	01/31/2025	5,878.65	1,607.60	4,271.05	478,009.02
86	02/28/2025	5,878.65	1,593.36	4,285.29	473,723.73
87	03/31/2025	5,878.65	1,579.08	4,299.57	469,424.16
88	04/30/2025	5,878.65	1,564.75	4,313.90	465,110.26
89	05/31/2025	5,878.65	1,550.37	4,328.28	460,781.98
90	06/30/2025	5,878.65	1,535.94	4,342.71	456,439.27
91	07/31/2025	5,878.65	1,521.46	4,357.19	452,082.08
92	08/31/2025	5,878.65	1,506.94	4,371.71	447,710.37
93	09/30/2025	5,878.65	1,492.37	4,386.28	443,324.09
94	10/31/2025	5,878.65	1,477.75	4,400.90	438,923.19
95	11/30/2025	5,878.65	1,463.08	4,415.57	434,507.62
96	12/31/2025	5,878.65	1,448.36	4,430.29	430,077.33
2025 Totals		70,543.80	18,341.06	52,202.74	
97	01/31/2026	5,878.65	1,433.59	4,445.06	425,632.27
98	02/28/2026	5,878.65	1,418.77	4,459.88	421,172.39
99	03/31/2026	5,878.65	1,403.91	4,474.74	416,697.65
100	04/30/2026	5,878.65	1,388.99	4,489.66	412,207.99
101	05/31/2026	5,878.65	1,374.03	4,504.62	407,703.37
102	06/30/2026	5,878.65	1,359.01	4,519.64	403,183.73
103	07/31/2026	5,878.65	1,343.95	4,534.70	398,649.03
104	08/31/2026	5,878.65	1,328.83	4,549.82	394,099.21
105	09/30/2026	5,878.65	1,313.66	4,564.99	389,534.22
106	10/31/2026	5,878.65	1,298.45	4,580.20	384,954.02
107	11/30/2026	5,878.65	1,283.18	4,595.47	380,358.55
108	12/31/2026	5,878.65	1,267.86	4,610.79	375,747.76
2026 Totals		70,543.80	16,214.23	54,329.57	
109	01/31/2027	5,878.65	1,252.49	4,626.16	371,121.60
110	02/28/2027	5,878.65	1,237.07	4,641.58	366,480.02
111	03/31/2027	5,878.65	1,221.60	4,657.05	361,822.97
112	04/30/2027	5,878.65	1,206.08	4,672.57	357,150.40
113	05/31/2027	5,878.65	1,190.50	4,688.15	352,462.25

Phil Loan

	Date	Payment	Interest	Principal	Balance
114	06/30/2027	5,878.65	1,174.87	4,703.78	347,758.47
115	07/31/2027	5,878.65	1,159.19	4,719.46	343,039.01
116	08/31/2027	5,878.65	1,143.46	4,735.19	338,303.82
117	09/30/2027	5,878.65	1,127.68	4,750.97	333,552.85
118	10/31/2027	5,878.65	1,111.84	4,766.81	328,786.04
119	11/30/2027	5,878.65	1,095.95	4,782.70	324,003.34
120	12/31/2027	5,878.65	1,080.01	4,798.64	319,204.70
2027 Totals		70,543.80	14,000.74	56,543.06	
121	01/31/2028	5,878.65	1,064.02	4,814.63	314,390.07
122	02/29/2028	5,878.65	1,047.97	4,830.68	309,559.39
123	03/31/2028	5,878.65	1,031.86	4,846.79	304,712.60
124	04/30/2028	5,878.65	1,015.71	4,862.94	299,849.66
125	05/31/2028	5,878.65	999.50	4,879.15	294,970.51
126	06/30/2028	5,878.65	983.24	4,895.41	290,075.10
127	07/31/2028	5,878.65	966.92	4,911.73	285,163.37
128	08/31/2028	5,878.65	950.54	4,928.11	280,235.26
129	09/30/2028	5,878.65	934.12	4,944.53	275,290.73
130	10/31/2028	5,878.65	917.64	4,961.01	270,329.72
131	11/30/2028	5,878.65	901.10	4,977.55	265,352.17
132	12/31/2028	5,878.65	884.51	4,994.14	260,358.03
2028 Totals		70,543.80	11,697.13	58,846.67	
133	01/31/2029	5,878.65	867.86	5,010.79	255,347.24
134	02/28/2029	5,878.65	851.16	5,027.49	250,319.75
135	03/31/2029	5,878.65	834.40	5,044.25	245,275.50
136	04/30/2029	5,878.65	817.59	5,061.06	240,214.44
137	05/31/2029	5,878.65	800.71	5,077.94	235,136.50
138	06/30/2029	5,878.65	783.79	5,094.86	230,041.64
139	07/31/2029	5,878.65	766.81	5,111.84	224,929.80
140	08/31/2029	5,878.65	749.77	5,128.88	219,800.92
141	09/30/2029	5,878.65	732.67	5,145.98	214,654.94
142	10/31/2029	5,878.65	715.52	5,163.13	209,491.81
143	11/30/2029	5,878.65	698.31	5,180.34	204,311.47
144	12/31/2029	5,878.65	681.04	5,197.61	199,113.86
2029 Totals		70,543.80	9,299.63	61,244.17	
145	01/31/2030	5,878.65	663.71	5,214.94	193,898.92
146	02/28/2030	5,878.65	646.33	5,232.32	188,666.60
147	03/31/2030	5,878.65	628.89	5,249.76	183,416.84
148	04/30/2030	5,878.65	611.39	5,267.26	178,149.58
149	05/31/2030	5,878.65	593.83	5,284.82	172,864.76
150	06/30/2030	5,878.65	576.22	5,302.43	167,562.33
151	07/31/2030	5,878.65	558.54	5,320.11	162,242.22
152	08/31/2030	5,878.65	540.81	5,337.84	156,904.38
153	09/30/2030	5,878.65	523.01	5,355.64	151,548.74
154	10/31/2030	5,878.65	505.16	5,373.49	146,175.25
155	11/30/2030	5,878.65	487.25	5,391.40	140,783.85
156	12/31/2030	5,878.65	469.28	5,409.37	135,374.48

Phil Loan

	Date	Payment	Interest	Principal	Balance
2030 Totals		70,543.80	6,804.42	63,739.38	
157	01/31/2031	5,878.65	451.25	5,427.40	129,947.08
158	02/28/2031	5,878.65	433.16	5,445.49	124,501.59
159	03/31/2031	5,878.65	415.01	5,463.64	119,037.95
160	04/30/2031	5,878.65	396.79	5,481.86	113,556.09
161	05/31/2031	5,878.65	378.52	5,500.13	108,055.96
162	06/30/2031	5,878.65	360.19	5,518.46	102,537.50
163	07/31/2031	5,878.65	341.79	5,536.86	97,000.64
164	08/31/2031	5,878.65	323.34	5,555.31	91,445.33
165	09/30/2031	5,878.65	304.82	5,573.83	85,871.50
166	10/31/2031	5,878.65	286.24	5,592.41	80,279.09
167	11/30/2031	5,878.65	267.60	5,611.05	74,668.04
168	12/31/2031	5,878.65	248.89	5,629.76	69,038.28
2031 Totals		70,543.80	4,207.60	66,336.20	
169	01/31/2032	5,878.65	230.13	5,648.52	63,389.76
170	02/29/2032	5,878.65	211.30	5,667.35	57,722.41
171	03/31/2032	5,878.65	192.41	5,686.24	52,036.17
172	04/30/2032	5,878.65	173.45	5,705.20	46,330.97
173	05/31/2032	5,878.65	154.44	5,724.21	40,606.76
174	06/30/2032	5,878.65	135.36	5,743.29	34,863.47
175	07/31/2032	5,878.65	116.21	5,762.44	29,101.03
176	08/31/2032	5,878.65	97.00	5,781.65	23,319.38
177	09/30/2032	5,878.65	77.73	5,800.92	17,518.46
178	10/31/2032	5,878.65	58.39	5,820.26	11,698.20
179	11/30/2032	5,878.65	38.99	5,839.66	5,858.54
180	12/31/2032	5,878.65	20.11	5,858.54	0.00
2032 Totals		70,543.80	1,505.52	69,038.28	
Grand Totals		1,058,157.00	263,410.04	794,746.96	

Phil Loan

Last interest amount increased by 0.58 due to rounding.