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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

Lori A. Shibinette
Commissioner

Patricia M. Tilley
Director

29 HAZEN DRIVE, CONCORD, NH 03301
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May 25, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to enter into contracts with the Contractors listed below in an amount not to exceed $8,158,520 to increase access to integrated prevention and primary health care services for Women, Infants, Children and Adolescents, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020, with the option to renew for up to four (4) additional years, effective upon Governor and Council approval through June 30, 2024. 10% Federal Funds. 90% General Funds.

Contractor Name	Vendor Code	Area Served	Contract Amount
Amoskeag Health	157274-B001	Manchester	$1,529,850
Concord Hospital, Inc.	177653-B011	Concord	$658,569
Coos County Family Health Services, Inc.	155327-B001	Berlin	$731,721
Greater Seacoast Community Health	166629-B001	Somersworth	$1,232,685
HealthFirst Family Care Center, Inc.	158221-B001	Franklin	$597,648
Lamprey Health Care, Inc.	177677-R001	Newmarket	$1,112,527
Manchester Health Department	177433-B009	Manchester	$412,006
Mid-State Health Center	158055-B001	Plymouth	$640,823
Weeks Medical Center	177171-R001	Lancaster	$617,806
White Mountain Community Health Center	174170-R001	Conway	$624,885
		Total:	**$8,158,520**

Funds are available in the following accounts for State Fiscal Years 2022 and 2023, and are anticipated to be available in State Fiscal Year 2024, upon the availability and continued appropriation of funds in the future operating budget, with the authority to adjust budget line items within the price limitation and encumbrances between state fiscal years through the Budget Office, if needed and justified.

See attached fiscal details.

EXPLANATION

The purpose of this request is for the Department to increase access to integrated prevention and primary health care for the Maternal and Child Health (MCH) target population of women, infants, children and adolescents, and to address the maternal and youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

Approximately 194,940 individuals will be served from June 1, 2022 to June 30, 2024.

The Contractors will provide increased access to healthcare for New Hampshire infants, children and adolescents from birth to 21 years of age, and pregnant women and women of childbearing age, and must not exclude individuals who are uninsured; underinsured; and/or considered low-income. Integrated prevention and primary health care services are provided to individuals who may experience barriers to accessing health care due to issues such as lack of insurance, inability to pay, limited language proficiency and geographic isolation. The Contractors will integrate and coordinate access to medical, behavioral and social services by reducing barriers to care through an array of services such as care coordination, translation services, outreach, eligibility assistance, transportation, and health education.

The Department will monitor services through the following performance measures:

- Percent of infants who were ever breastfed.
- Percent of adolescents 12 to 21 years of age who had at least one (1) comprehensive well-care visit/comprehensive physical exam during the measurement year.
- Percent of postpartum women screened for clinical depression during any visit up to 12 weeks following delivery using an appropriate standardized depression screening tool AND if positive screen, a follow-up plan is documented on the date of the positive screen.

The Department selected the Contractors through a competitive bid process using a Request for Proposals (RFP) that was posted on the Department's website from January 14, 2022 through February 25, 2022. The Department received 10 responses that were reviewed and scored by a team of qualified individuals. The Scoring Sheet is attached.

As referenced in Exhibit A, Revisions to Standard Agreement Provisions, of the attached agreements, the parties have the option to extend the agreements for up to four (4) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and Governor and Council approval.

Should the Governor and Executive Council not authorize this request, the Department may be unable to ensure increased access to healthcare for New Hampshire infants, children and adolescents from birth to 21 years of age, pregnant women and women of childbearing age, and individuals who are uninsured; underinsured; considered low-income.

Source of Federal Funds: CFDA #93.994, FAIN B04MC45230

In the event that the Federal Funds become no longer available, additional General Funds will not be requested to support this program.

Respectfully submitted,

DocuSigned by:
Ann H. Landry
24BAB37EDBEB488...

Lori A. Shibinette
Commissioner

Maternal and Child Health in the Integrated Primary Care Setting
RFP-2022-DPHS-19-PRIMA
Fiscal Detail Sheet

05-95-90-902010-5190 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: PUBLIC HEALTH DIV, BUREAU OF COMM & HEALTH SERV, MATERNAL - CHILD HEALTH

1. Amoskeag Health, Vendor # 157274-B001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$161,194
SFY 2023	102-500731	Contracts for Program Services	90080112	$684,328
SFY 2024	102-500731	Contracts for Program Services	90080112	$684,328
			Subtotal:	*$1,529,850*

2. Concord Hospital, Inc., Vendor # 177653-B011 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$26,343
SFY 2023	102-500731	Contracts for Program Services	90080112	$316,113
SFY 2024	102-500731	Contracts for Program Services	90080112	$316,113
			Subtotal:	*$658,569*

3. Coos County Family Health Services, Inc., Vendor # 155327-B001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$29,269
SFY 2023	102-500731	Contracts for Program Services	90080112	$351,226
SFY 2024	102-500731	Contracts for Program Services	90080112	$351,226
			Subtotal:	*$731,721*

4. Greater Seacoast Community Health, Vendor # 166629-B001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$49,307
SFY 2023	102-500731	Contracts for Program Services	90080112	$591,689
SFY 2024	102-500731	Contracts for Program Services	90080112	$591,689
			Subtotal:	*$1,232,685*

5. Health First Family Care Center, Vendor # 158221-B001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$23,906
SFY 2023	102-500731	Contracts for Program Services	90080112	$286,871
SFY 2024	102-500731	Contracts for Program Services	90080112	$286,871
			Subtotal:	*$597,648*

6. Lamprey Health Care, Inc., Vendor # 177677-R001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$44,501
SFY 2023	102-500731	Contracts for Program Services	90080112	$534,013
SFY 2024	102-500731	Contracts for Program Services	90080112	$534,013
			Subtotal:	*$1,112,527*

Maternal and Child Health in the Integrated Primary Care Setting
RFP-2022-DPHS-19-PRIMA

7. Manchester Health Dept. Vendor #177433-B009 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$16,480
SFY 2023	102-500731	Contracts for Program Services	90080112	$197,763
SFY 2024	102-500731	Contracts for Program Services	90080112	$197,763
			Subtotal:	*$412,006*

8. Mid-State Health Center, Vendor # 158055-B001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$25,633
SFY 2023	102-500731	Contracts for Program Services	90080112	$307,595
SFY 2024	102-500731	Contracts for Program Services	90080112	$307,595
			Subtotal:	*$640,823*

9. Weeks Medical Center, Vendor # 177171-R001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$24,712
SFY 2023	102-500731	Contracts for Program Services	90080112	$296,547
SFY 2024	102-500731	Contracts for Program Services	90080112	$296,547
			Subtotal:	*$617,806*

10. White Mountain Community Health Center, Vendor # 174170-R001 (10% Federal Funds and 90% General Funds)

Fiscal Year	Class / Account	Class Title	Job Number	Budget Amount
SFY 2022	102-500731	Contracts for Program Services	90080112	$24,995
SFY 2023	102-500731	Contracts for Program Services	90080112	$299,945
SFY 2024	102-500731	Contracts for Program Services	90080112	$299,945
			Subtotal:	*$624,885*
			TOTAL:	**$8,158,520**

New Hampshire Department of Health and Human Services
Division of Finance and Procurement
Bureau of Contracts and Procurement
Scoring Sheet

Project ID # RFP-2022-DPHS-19-PRIMA

Project Title Maternal and Child Health Care in the Integrated Primary Care Setting

	Maximum Points Available	Amoskeag Health	City of Manchester Health Department	Concord Hospital Family Health Center	Coos County Family Health Services	Greater Seacoast Community Health	HealthFirst Family Care Center Inc	Lamprey Healthcare	Mid-State Health	Weeks Medical Center	White Mountain Community Health Center
Technical											
Primary Care Services (Q1)	30	28	24	25	23	29	25	25	28	25	28
Social Determinants of Health (Q2)	20	20	18	13	18	20	18	15	18	15	18
Enabling Service Initiatives (Q3)	20	20	18	14	18	19	18	13	19	18	16
Quality Improvement Projects (Q4)	20	20	20	12	17	18	18	17	15	18	16
Staffing (Q5)	5	3	3	3	3	5	4	2	4	3	3
and Training Plan (Q6)	5	4	3	3	3	5	4	5	4	4	2
Technical Score*	**100**	**95**	**86**	**70**	**82**	**96**	**87**	**77**	**88**	**83**	**83**
TOTAL SCORE	**100**	**95**	**86**	**70**	**82**	**96**	**87**	**77**	**88**	**83**	**83**

**Minimum Passing Technical Score = 70 of 100 possible points.*

	Reviewer Name	Title
1	Rhonda Siegel	Administrator
2	Shari Campbell	Program Specialist III
3	Erica Tenney	Program Coordinator
4	Lisa Storez	Public Health Nurse Consultant
5	Ellen Stickney	Public Health Nurse Coordinator

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-01)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Amoskeag Health		1.4 Contractor Address 145 Hollis St. Manchester, NH 03101	
1.5 Contractor Phone Number (603) 626-5210	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $1,529,850
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: C02AF839C83F434... Date: 5/17/2022		1.12 Name and Title of Contractor Signatory Kris McCracken President/CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt D778EB63F970AC7 Date: 5/25/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino 748734844041480... On: 5/25/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials DS
Date 5/17/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

Contractor Initials DS

Date 5/17/2022

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

Contractor Initials

Date 5/17/2022

Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

Contractor Initials DS

Date 5/17/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Increase Lactation Support to Postpartum Women, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Well Visit, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): M-CHAT Screening, in accodance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

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1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

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license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

       Financial Manager
       Department of Health and Human Services
       129 Pleasant Street
       Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

Exhibit C-1, Budget

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Amoskeag Health*

Budget Request for: *Primary Care Services*

Budget Period *6/1/22 – 6/30/22*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$130,503
2. Fringe Benefits	$15,269
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Subcontracts/Agreements - Transportation	$768
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$146,540
Total Indirect Costs	$14,654
TOTAL	**$161,194**

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Contractor Initials_____

Date 5/17/2022

Exhibit C-2, Budget

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Amoskeag Health*

Budget Request for: *Primary Care Services*

Budget Period *July 1, 2022 - June 30, 2023*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$554,123
2. Fringe Benefits	$64,832
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Subcontracts/Agreements - Transportation	$3,161
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$622,116
Total Indirect Costs	$62,212
TOTAL	**$684,328**

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Contractor Initials_____

Date 5/17/2022

Exhibit C-3, Budget

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Amoskeag Health*

Budget Request for: *Primary Care Services*

Budget Period *July 1, 2023 - June 30, 2024*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$554,294
2. Fringe Benefits	$64,852
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Subcontracts/Agreements - Transportation	$2,970
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$622,116
Total Indirect Costs	$62,212
TOTAL	**$684,328**

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Contractor Initials_____

Date 5/17/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

Vendor Initials DS

Date 5/17/2022

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

DocuSigned by:

5/17/2022
Date

Name: Kris McCracken
Title: President/CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

DocuSigned by:

5/17/2022
Date

Name: Kris McCracken
Title: President/CEO

DS

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials DS

Date 5/17/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

DocuSigned by:

5/17/2022
Date

C52AF0190B5F45...
Name: Kris McCracken
Title: President/CEO

DS

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:

5/17/2022

Date

Name: Kris McCracken

Title: President/CEO

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
C32AF839C85F434...

5/17/2022
Date

Name: Kris McCracken
Title: President/CEO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) **Definitions**.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

Contractor Initials _____

Date 5/17/2022

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Amoskeag Health
The State	Name of the Contractor
Docusigned by: Iain Watt	Docusigned by:
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Kris McCracken
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	President/CEO
Title of Authorized Representative	Title of Authorized Representative
5/25/2022	5/17/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:

5/17/2022
Date

Name: Kris McCracken
Title: President/CEO

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 9286649370000

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening and Refrrals for SDOH Work Plan

Enabling Services Work Plan #1			
Agency Name: Amoskeag Health **Role of Person(s) Completing Work Plan:** Dr. Gavin Muir & Kris McCracken			
Enabling Services Focus Area: Screening and Referrals for SDOH			
Project Goal: Assist patients in accessing healthcare by identifying and assisting with patient barriers related to social determinants of health			
Project Objective: 45%			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list foreach activity)	Evaluation Plans (list as needed for each activity).	Timeline for Activity (estimated timeline for the duration of each activity)
Complete implementation of Simple Interact Patient Engagement software and automate annual screening for SDOH related issues.	Project Manager, Patient Access Coordinator, Case Management leadership team.	Monthly audits of EMR to track numbers completed	July 1, 2022
Update the amount of current cell phone numbers on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Diabetic Educator, Nutritionist	Monthly audits of EMR to track percentage of patients with cell phone on file	December 31, 2022
Improve the number of patients with a current email on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Diabetic Educator, Nutritionist	Monthly audits of EMR to track percentage of patients with email on file	December 31, 2022
Revise new patient workflow to include initial SDOH screen	Patient Access Coordinator, Project Manager	Simple Interact Implementation Team to monitor progress	July 1, 2022
Revise established patient workflow and utilize EMR to generate lists of patients over 365 days since last screen	Project Manager, Healthcare Data Analyst	Simple Interact Implementation Team to monitor progress	July 1, 2022
Oversight by QI leadership team of progress, QI Ops team to assist with implementing changes if needed	CMO, CEO, Healthcare Data Analyst, QI Operations Team	Monthly audits of EMR to track progress	Q6 months during contract period per agreement

DS

Contractor Initials _____

Date 5/17/2022

Attachment #1 – Screening and Refrrals for SDOH Work Plan

Enabling Service Work Plan Progress Report TemplateEnabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #1 – Screening and Refrrals for SDOH Work Plan

July 2023 Project UpdateSFY23 Outcome (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	___Yes ___No
July 2023 Project Update SFY23 Narrative: If met--Explain what happened during the year that contributedto the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update SFY23 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Attachment #1 – Screening and Refrrals for SDOH Work Plan

Work Plan Revisions submitted: _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributedto the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 – Lactation Support Work Plan

Enabling Services Work Plan #2			
Agency Name: Amoskeag Health **Role of Person(s) Completing Work Plan:** Dr. Gavin Muir & Kris McCracken			
Enabling Services Focus Area: Increasing number of postpartum women who have lactation support			
Project Goal: Increase number of women who are breastfeeding by providing support post partum.			
Project Objective: 20% (new goal- no current data)			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list foreach activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Engage prenatal team to more aggressively promote the benefits of breastfeeding to our pregnant population	Nurse Specialty Services Coordinator, CMO, Prenatal Team	Monthly audit of EMR to assess progress on this measure	July 2022
Engage Nutritionist in developing outreach plan to follow up on individuals that have identified an interest in receiving lactation support	Interpreter Staff, Nurse Specialty Services Coordinator, Nutritionist	Monthly audit of EMR to assess progress on this measure	July 2022
Create an education campaign including all social media options, website, Patient Point and Simple Interact to increase knowledge of our patient population about the availability of lactation support services and the benefits of breast feeding	Communications & Marketing Specialist, Interpreter Staff, Staff Clinical Educator, Nurse Specialty Services Coordinator, CNO, CMO, Prenatal Team, Nutritionist, Project Manager (Simple Interact)	Monthly audit of EMR to assess progress on this measure	October 2022
Engage interpreter staff to explore/ discuss cultural norms in our various demographic groups regarding breast feeding and strategize on potential educational opportunities that are culturally informed	Interpreter Staff, Staff Clinical Educator, Nurse Specialty Services Coordinator, CNO, CMO, Prenatal Team, Nutritionist	Monthly audit of EMR to assess progress on this measure	July 2022

Attachment #2 – Lactation Support Work Plan

Enabling Services Work Plan #2 **Agency Name:** Amoskeag Health **Name and Role of Person(s) Completing Work Plan:** Dr. Gavin Muir & Kris McCracken	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #2 – Lactation Support Work Plan

July 2023 Project UpdateSFY23 Outcome (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update SFY23 Narrative: If met--Explain what happened during the year that contributedto the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update SFY23 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Attachment #2 – Lactation Support Work Plan

Work Plan Revisions submitted: _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributedto the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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5/17/2022

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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5/17/2022

Attachment #4, "Adolescent Well Visit" Work Plan

Quality Improvement Work Plan #1 **Agency Name:** Amoskeag Health **Name and Role of Person(s) Completing Work Plan:** Dr. Gavin Muir & Kris McCracken			
MCH Performance Measure: Adolescent Well Visits			
Project Goal: To assure our adolescent patients have access to regular screening, necessary vaccinations, and any additional services they may need on at least an annual basis.			
Project Objective: 55%			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list foreach activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Complete implementation of Simple Interact Patient Engagement software and automate annual health maintenance visit reminders	Project Manager, Patient Care Coordinators, Interpreters	Monthly audits of EMR to track numbers completed	October 2022
Update the amount of current cell phone numbers on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Patient Care Coordinators	Monthly audits of EMR to track percentage of patients with cell phone on file	July 2022
Improve the number of patients with a current email on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Patient Care Coordinators	Monthly audits of EMR to track percentage of patients with email on file	July 2022
Incentivize key staff as a part of quarterly initiatives.	CMO, CNO, CFO and clinical team	Audits of CPS Registration and Scheduling system for scheduling level activity	January 2022

QI Work Plan Progress ReportPerformance Measure: Project Objective:	

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Attachment #4, "Adolescent Well Visit" Work Plan

July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update	

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No

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Attachment #4, "Adolescent Well Visit" Work Plan

July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributedto the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	

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Contractor Initials _____

Date 5/17/2022

Attachment #4, "Adolescent Well Visit" Work Plan

SFY24 Narrative: If met--Explain what happened during the year that contributedto the success If NOT met—what barriers were experienced, what will be done differentlyto meet the target over the next year	

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Contractor Initials _____

Date 5/17/2022

Attachment #5 – M-Chat Screening

Quality Improvement Work Plan #2 **Agency Name:** Amoskeag Health **Name and Role of Person(s) Completing Work Plan:** Dr. Gavin Muir & Kris McCracken			
MCH Performance Measure: M-CHAT Screening			
Project Goal: Increase number of children screened for autism in early childhood.			
Project Objective: 75%			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list foreach activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Complete implementation of Simple Interact Patient Engagement software and automate health maintenance visit reminders	Project Manager, Patient Care Coordinators, Interpreters	Monthly audits of EMR to track numbers completed	October 2022
Prep patient charts with reminder at appropriate ages to complete M-CHAT if not completed during pre-visit process with Simple Interact	Immunization Coordinators	Feedback from provider staff about preparedness of chart during department meetings.	May 2022
Utilize Simple Interact to complete M-CHAT in advance of visit	Project Manager, Patient Care Coordinators, Interpreters	Monthly Audits of EMR to track percentage of patients with M-CHAT completed	October 2022
Update the amount of current cell phone numbers on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Patient Care Coordinators	Monthly audits of EMR to track percentage of patients with cell phone on file	July 2022
Improve the number of patients with a current email on file	Patient Access Coordinator, Call Center Coordinator, Interpreter Staff, Patient Care Coordinators	Monthly audits of EMR to track percentage of patients with email on file	July 2022

Attachment #5 – M-Chat Screening

QI Work Plan Progress ReportPerformance Measure: Project Objective:	
July 2022 Progress Report— • Are you on track with the workplan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective.If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** ____Yes ____No	
January 2023 Progress Report— • Are you on track with the workplan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective.If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** ____Yes ____No	
July 2023 Project Update	

Attachment #5 – M-Chat Screening

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributedto the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities; evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	

Attachment #5 – M-Chat Screening

SFY24 Narrative: If met--Explain what happened during the year that contributedto the success If NOT met—what barriers were experienced, what will be done differentlyto meet the target over the next year	

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. Breastfeeding

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. Preventive Health: Lead Testing

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

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Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

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Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

DS

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

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5/17/2022

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS

5/17/2022

State of New Hampshire

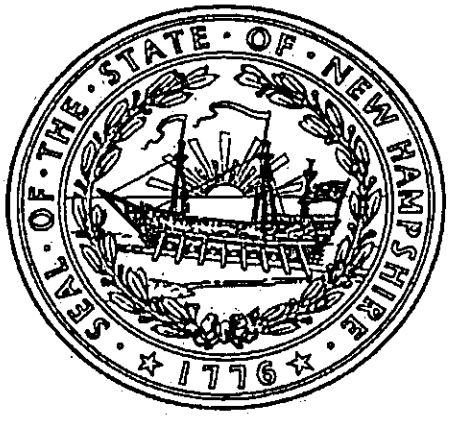
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that AMOSKEAG HEALTH is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on May 07, 1992. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **175115**

Certificate Number: **0005749996**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 5th day of April A.D. 2022.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, David Crespo hereby certify that: I am a duly elected Clerk/Secretary/Officer of Amoskeag Health

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on 05/03/2022 at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Kris McCracken is duly authorized on behalf of Amoskeag Health to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to affect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 5/3/22

Signature of Elected Officer
Name: David Crespo
Title: Secretary

DocuSign Envelope ID: 880DA691-1328-4A56-8199-AB724689D3E8

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/10/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Jen Paquin	
Optisure Risk Partner, LLC d/b/a Aspen Insurance Agency 40 Stark Street Manchester NH 03101	PHONE (A/C, No, Ext): (603) 647-0800	FAX (A/C, No): (603) 647-0330
	E-MAIL ADDRESS: Jen.paquin@optisure.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Selective Insurance Company	
	INSURER B : Comp-SIGMA Ltd	
	INSURER C : Hanover Professionals Direct	
	INSURER D :	
	INSURER E :	
	INSURER F :	

INSURED
AMOSKEAG HEALTH
145 HOLLIS STREET
MANCHESTER NH 03101

COVERAGES **CERTIFICATE NUMBER:** CL222116479 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			S 2438257	11/01/2021	11/01/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 300,000 $ 10,000 $ $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [X] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			S 2438257	11/01/2021	11/01/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	[X] UMBRELLA LIAB [X] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $			S 2438257	11/01/2021	11/01/2022	EACH OCCURRENCE AGGREGATE	$ 4,000,000 $ 4,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [Y] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		HCHS20220000588	01/01/2022	01/01/2023	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
C	FTCA Gap Excess Prof Liability FTCA Gap Professional Liab			L3VA515491 & L1V0305375	07/01/2021	07/01/2022	Each Incident Aggregate	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

State of NH
Dept of Health & Human Service
129 Pleasant Street
Concord NH 03301-3857

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

AMOSKEAG HEALTH

MISSION

To improve the health and well-being of our patients and the communities we serve by providing exceptional care and services that are accessible to all.

VISION

We envision a healthy and vibrant community with strong families and tight social fabric that ensures everyone has the tools they need to thrive and succeed.

CORE VALUES

We believe in:

- Promoting wellness and empowering patients through education
- Removing barriers so that our patients achieve and maintain their best possible health
- Providing exceptional, evidence-based and patient-centered care
- Fostering an environment of respect, integrity and caring where all people are treated equally with dignity and courtesy

BerryDunn

AMOSKEAG HEALTH

FINANCIAL STATEMENTS

June 30, 2021 and 2020

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Amoskeag Health

We have audited the accompanying financial statements of Amoskeag Health, which comprise the balance sheets as of June 30, 2021 and 2020, and the related statements of operations, functional expenses, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Amoskeag Health as of June 30, 2021 and 2020, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, during the year ended June 30, 2021, Amoskeag Health adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance. Our opinion is not modified with respect to this matter.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
November 2, 2021

AMOSKEAG HEALTH

Balance Sheets

June 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 4,731,957	$ 3,848,925
Patient accounts receivable	1,806,238	1,650,543
Grants and other receivables	880,300	985,801
Other current assets	300,180	114,920
Total current assets	7,718,675	6,600,189
Property and equipment, net	4,152,995	4,249,451
Total assets	$11,871,670	$10,849,640

LIABILITIES AND NET ASSETS

Current liabilities		
Line of credit	$ -	$ 450,000
Accounts payable and accrued expenses	754,413	526,311
Accrued payroll and related expenses	1,723,122	1,473,665
Paycheck Protection Program refundable advance	-	1,467,800
Current maturities of long-term debt	52,072	42,505
Total current liabilities	2,529,607	3,960,281
Long-term debt, less current maturities	1,503,059	1,556,661
Total liabilities	4,032,666	5,516,942
Net assets		
Without donor restrictions	7,054,282	4,711,819
With donor restrictions	784,722	620,879
Total net assets	7,839,004	5,332,698
Total liabilities and net assets	$11,871,670	$10,849,640

The accompanying notes are an integral part of these financial statements.

AMOSKEAG HEALTH

Statements of Operations

Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenue		
Net patient service revenue	**$11,123,864**	$10,792,094
Grants, contracts and support	**9,926,932**	8,334,383
Paycheck Protection Program loan forgiveness	**1,467,800**	-
Other operating revenue	**110,480**	264,523
Net assets released from restriction for operations	**1,026,327**	1,014,296
Total operating revenue	**23,655,403**	20,405,296
Operating expenses		
Salaries and wages	**13,238,880**	12,918,995
Employee benefits	**2,551,855**	2,423,466
Program supplies	**536,720**	519,960
Contracted services	**2,724,436**	2,211,397
Occupancy	**829,588**	725,333
Other	**868,512**	789,982
Depreciation and amortization	**500,368**	426,791
Interest	**62,581**	86,838
Total operating expenses	**21,312,940**	20,102,762
Excess of revenue over expenses and increase in net assets without donor restrictions	**$ 2,342,463**	$ 302,534

The accompanying notes are an integral part of these financial statements.

AMOSKEAG HEALTH

Statements of Functional Expenses

Years Ended June 30, 2021 and 2020

	2021											
	Healthcare Services								Administrative and Support Services			
	Non-clinical Support Services	Enabling Services	Behavioral Health	Pharmacy	Medical	Special Medical Programs	Community Services	Total Healthcare Services	Facility	Marketing and Fundraising	Administration	Total
Salaries and wages	$ 1,443,105	$ 572,404	$ 2,179,922	$ 69,028	$ 5,916,509	$ 832,105	$ 275,664	$11,288,737	$ 132,793	$ 165,591	$ 1,651,759	$13,238,880
Employee benefits	279,237	115,773	463,013	17,219	1,018,387	149,979	57,331	2,100,939	23,902	31,089	395,925	2,551,855
Program supplies	1,030	2,259	46,502	181,901	253,478	10,685	28,469	524,324	110	6,004	6,282	536,720
Contracted services	206,814	280,152	122,384	311,761	762,194	347,396	351,447	2,382,148	-	16,018	326,270	2,724,436
Occupancy	105,110	14,372	92,022	3,700	587,893	100,856	-	903,953	(530,075)	14,926	440,784	829,588
Other	78,320	8,310	68,944	-	160,715	18,080	20,064	354,433	72,395	39,600	402,084	868,512
Depreciation and amortization	566	-	14,276	-	95,931	569	1,573	112,915	242,975	504	143,974	500,368
Interest	-	-	-	-	-	-	-	-	58,146	-	4,435	62,581
Total	$ 2,114,182	$ 993,270	$ 2,987,063	$ 583,609	$ 8,795,107	$ 1,459,670	$ 734,548	$17,667,449	$ 246	$ 273,732	$ 3,371,513	$21,312,940

	2020											
	Healthcare Services								Administrative and Support Services			
	Non-clinical Support Services	Enabling Services	Behavioral Health	Pharmacy	Medical	Special Medical Programs	Community Services	Total Healthcare Services	Facility	Marketing and Fundraising	Administration	Total
Salaries and wages	$ 1,718,516	$ 526,822	$ 1,927,974	$ 79,500	$ 5,631,705	$ 842,162	$ 236,825	$10,963,504	$ 125,802	$ 158,008	$ 1,671,681	$12,918,995
Employee benefits	323,122	98,862	360,012	14,705	984,467	154,645	42,814	1,978,627	23,506	28,852	392,481	2,423,466
Program supplies	1,308	2,966	58,720	197,339	231,140	7,369	8,622	507,464	1,419	-	11,077	519,960
Contracted services	152,425	265,070	197,932	338,328	474,948	361,030	166,451	1,956,184	14,136	14,036	227,041	2,211,397
Occupancy	114,192	15,814	99,973	4,020	635,524	109,571	-	979,094	(524,235)	16,216	254,258	725,333
Other	69,816	5,692	87,212	435	101,999	20,137	42,731	328,022	55,165	22,673	384,122	789,982
Depreciation and amortization	205	-	11,358	-	50,809	569	1,224	64,165	241,318	462	120,846	426,791
Interest	-	-	-	-	-	-	-	-	62,889	-	23,949	86,838
Total	$ 2,379,584	$ 915,226	$ 2,743,181	$ 634,327	$ 8,110,592	$ 1,495,483	$ 498,667	$16,777,060	$ -	$ 240,247	$ 3,085,455	$20,102,762

The accompanying notes are an integral part of these financial statements.

AMOSKEAG HEALTH

Statements of Changes in Net Assets

Years Ended June 30, 2021 and 2020

	2021	2020
Net assets without donor restrictions		
Excess of revenue over expenses and increase in net assets without donor restrictions	$ 2,342,463	$ 302,534
Net assets with donor restrictions		
Contributions	1,190,170	1,028,655
Net assets released from restriction for operations	(1,026,327)	(1,014,296)
Increase in net assets with donor restrictions	163,843	14,359
Change in net assets	2,506,306	316,893
Net assets, beginning of year	5,332,698	5,015,805
Net assets, end of year	$ 7,839,004	$ 5,332,698

The accompanying notes are an integral part of these financial statements.

AMOSKEAG HEALTH

Statements of Cash Flows

Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	$ 2,506,306	$ 316,893
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	500,368	426,791
Equity in loss from limited liability company	-	6,877
(Increase) decrease in the following assets		
Patient accounts receivable	(155,695)	240,140
Grants and other receivables	105,501	77,662
Other current assets	(185,260)	40,441
Increase (decrease) in the following liabilities		
Accounts payable and accrued expenses	228,102	(50,312)
Accrued payroll and related expenses	249,457	262,775
Paycheck Protection Program refundable advance	(1,467,800)	1,467,800
Net cash provided by operating activities	1,780,979	2,789,067
Cash flows from investing activities		
Distribution from limited liability company	-	12,223
Capital expenditures	(399,526)	(274,832)
Net cash used by investing activities	(399,526)	(262,609)
Cash flows from financing activities		
Payments on line of credit	(450,000)	-
Payments on long-term debt	(48,421)	(46,368)
Net cash used by financing activities	(498,421)	(46,368)
Net increase in cash and cash equivalents	883,032	2,480,090
Cash and cash equivalents, beginning of year	3,848,925	1,368,835
Cash and cash equivalents, end of year	$ 4,731,957	$ 3,848,925
Supplemental disclosures of cash flow information		
Cash paid for interest	$ 62,581	$ 86,838

The accompanying notes are an integral part of these financial statements.

Organization

Amoskeag Health (the Organization) is a not-for-profit corporation organized in Manchester, New Hampshire. The Organization is a Federally Qualified Health Center (FQHC) providing high-quality, comprehensive, and family-oriented primary health care and support services, which meet the needs of a diverse community, regardless of age, ethnicity or income.

1. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Organization have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which requires the Organization to report information in the financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of the Organization's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

The Organization is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, the Organization is exempt from state and federal income taxes on income earned in accordance with its tax-exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the financial statements.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the Center for Disease Control and Prevention, the Organization took steps to create safe distances between both staff and patients. Medical and behavioral health patient visits were done through telehealth when appropriate.

The Organization received a loan in the amount of $1,467,800 in April 2020 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act. The PPP is subject to forgiveness, upon the Organization's request, to the extent that the proceeds are used to pay qualifying expenditures, including payroll costs, rent and utilities, incurred by the Organization during a specific covered period. The Organization is following the conditional contribution model to account for the PPP and determined the conditions for forgiveness were substantially met during the year ended June 30, 2021. The Organization was notified in May 2021 the PPP was fully forgiven by the SBA.

The Organization received a loan in the amount of $250,000 in July 2020 from the COVID-19 Emergency Healthcare System Relief Fund (Relief Loan), a program implemented by the State of New Hampshire, Department of Health and Human Services. The Relief Loan is unsecured, is interest free, and has a maturity date of 180 days after the expiration of the State of Emergency declared by the Governor, at which time the loan is due in full. The Relief Loan has the potential to be converted to a grant at the discretion of the Governor if certain criteria are met. The Organization submitted an application to convert the Relief Loan to a grant during 2021, which was approved and recognized as revenue.

The CARES Act and the PPPHCE Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services (HHS). During 2020, the Organization received PRF in the amount of $214,172. The Organization incurred qualifying revenue losses and recognized the PRF in full during the year ended June 30, 2020.

Cash and Cash Equivalents

Cash and cash equivalents consist of demand deposits, money market funds and petty cash.

The Organization has cash deposits in major financial institutions which exceed federal depository insurance limits. The Organization has not experienced losses in such accounts and management believes the credit risk related to these deposits is minimal.

Revenue Recognition and Patient Accounts Receivable

The Organization has adopted Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance, which supersedes accounting standards that previously existed under U.S. GAAP and provides a single revenue model to address revenue recognition to be applied by all companies. Under the new standard, organizations recognize revenue when a customer obtains control of promised goods or services in an amount that reflects the consideration to which the organization expects to be entitled in exchange for those goods and services. Topic 606 also requires organizations to disclose additional information, including the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The Organization elected to adopt this ASU retrospectively with the cumulative effect recognized at the date of initial application; therefore, the financial statements and related notes have been presented accordingly.

The adoption of Topic 606 changed how implicit price concessions are presented in the financial statements. Under the previous standards, the estimate for amounts not expected to be collected based upon historical experience was reflected as a provision for doubtful accounts, and presented separately as an offset to net patient service revenue. Under the new standards, the estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue, but not reflected separately as provision for doubtful accounts.

The impact of the adoption on the statement of operations for the year ended June 30, 2020 was as follows:

	As Originally Reported	Adjustments due to Topic 606 Adoption	Revised Balance
Patient service revenue	$ 11,473,557	$ (681,463)	$ 10,792,094
Provision for bad debts	(681,463)	681,463	-
Net patient service revenue	$ 10,792,094	$ -	$ 10,792,094

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payors (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Organization. The Organization measures the performance obligation for medical, behavioral health and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Organization measures the performance obligation for contract pharmacy services based on when the prescription is dispensed to the patient. The Organization's performance obligations are satisfied at a point in time.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience.

Consistent with the Organization's mission and FQHC designation, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Organization expects to collect based on its collection history with those patients.

The Organization has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payor. In assessing collectability, the Organization has elected the portfolio approach. The portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers (patients). The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payor or group of payors will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. payor concentrations are disclosed in Note 7.

The Organization bills the patients and third-party payors several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Organization is primarily reimbursed for medical and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Medicaid and Other Payors

The Organization has also entered into payment agreements with Medicaid and certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Organization is reimbursed for services based on contractually obligated payment rates, which may be less than the Organization's public fee schedule.

Patients

The Organization provides care to patients who meet certain criteria under its sliding fee discount policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization sliding fee discount policy amounted to $2,662,554 and $2,432,740 for the years ended June 30, 2021 and 2020, respectively. The Organization is able to provide these services with a component of funds received through local community support and federal grants.

For uninsured patients who do not qualify under the Organization's sliding fee discount program, the Organization bills the patient based on the Organization's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

340B Contract Pharmacy Program Revenue

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. This program requires drug manufacturers to provide outpatient drugs to FQHCs and other covered entities at a reduced price. The Organization contracts with other local pharmacies under this program. The contract pharmacies dispense drugs to eligible patients of the Organization and bill commercial insurances on behalf of the Organization. Reimbursement received by the contract pharmacies is remitted to the Organization, less dispensing and administrative fees. The dispensing and administrative fees are costs of the program and not deemed to be implicit price concessions which would reduce the transaction price.

Laws and regulations governing the Medicare, Medicaid and 340B programs are complex and subject to interpretation. Management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare, Medicaid, and 340B programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances and consisted of the following at June 30:

	2021	2020
Medical and dental patient accounts receivable	$ 1,710,630	$ 1,532,554
Contract 340B pharmacy program receivables	95,608	117,989
Total patient accounts receivable	$ 1,806,238	$ 1,650,543

Accounts receivable at July 1, 2019 were $1,890,683.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The accounts receivable from patients and third-party payors, net of contractual allowances, were as follows:

	2021	2020
Governmental plans		
Medicare	15 %	20 %
Medicaid	44 %	32 %
Commercial payors	19 %	31 %
Patient	22 %	17 %
Total	100 %	100 %

Grants and Other Receivables

Grants receivable are stated at the amount management expects to collect from outstanding balances. All such amount are considered collectible.

A portion of the Organization's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Organization has incurred expenditures in compliance with specific contract or grant provisions. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue. The Organization has been awarded cost reimbursable grants of $6,625,746 and $5,557,242 that have not been recognized at June 30, 2021 and 2020, respectively, because qualifying expenditures have not yet been incurred. The Organization also has been awarded $3,372,763 in cost-reimbursable grants with a project period beginning July 1, 2019.

The Organization receives a significant amount of grants from HHS. As with all government funding, these grants are subject to reduction or termination in future years. For the years ended June 30, 2021 and 2020, grants from HHS (including both direct awards and awards passed through other organizations) represented approximately 68% and 58%, respectively, of grants, contracts and support revenue.

Property and Equipment

Property and equipment are carried at cost. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. The Organization's capitalization policy is applicable for acquisitions greater than $1,000.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restriction.

Functional Expenses

The financial statements report certain categories of expenses that are attributable to more than one program or supporting function. Therefore, these expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include depreciation, interest, and office and occupancy costs, which are allocated on a square-footage basis, as well as the shared systems technology fees for the Organization's medical records and billing system, which are allocated based on the percentage of patients served by each function.

Reclassifications

Donor restricted contributions of $308,131 recorded as deferred revenue at June 30, 2020 were reclassified to contributions with donor restrictions for the year ended June 30, 2020 as it was determined there was no requirement to return the contributions. The reclassification resulted in an increase in the change in net asset of $308,131 for the year ended June 30, 2020.

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through November 2, 2021, the date that the financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

2. Availability and Liquidity of Financial Assets

The Organization regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents and a $1,000,000 line of credit (Note 4).

The Organization had working capital of $5,189,068 and $2,639,908 at June 30, 2021 and 2020, respectively. The Organization's goal is generally to have, at the minimum, the Health Resources and Services Administration recommended days cash on hand for operations of 30 days. The Organization had average days (based on normal expenditures) cash and cash equivalents on hand of 83 and 71 at June 30, 2021 and 2020, respectively.

Financial assets available for general expenditure within one year were as follows:

	2021	2020
Cash and cash equivalents	$ 4,731,957	$ 3,848,925
Patient accounts receivable	1,806,238	1,650,543
Grants and other receivables	880,300	985,801
Financial assets available	7,418,495	6,485,269
Less net assets with donor restrictions	784,722	620,879
Financial assets available for general expenditure	$ 6,633,773	$ 5,864,390

3. Property and Equipment

Property and equipment consist of the following as of June 30:

	2021	2020
Land	$ 81,000	$ 81,000
Building and leasehold improvements	5,330,228	5,165,754
Furniture and equipment	2,590,248	2,355,196
Total cost	8,001,476	7,601,950
Less accumulated depreciation	3,848,481	3,352,499
Property and equipment, net	$ 4,152,995	$ 4,249,451

Property and equipment acquired with Federal grant funds are subject to specific federal standards for sales and other dispositions. In many cases, the Federal government retains a residual ownership interest in the assets, requiring prior approval and restrictions on disposition.

4. Line of Credit

The Organization has a $1,000,000 line of credit demand note with a local banking institution with interest at the LIBOR rate plus 2.75% (3.98% at June 30, 2021). The line of credit is collateralized by all assets. There was an outstanding balance on the line of credit of $450,000 at June 30, 2020. There was no balance outstanding at June 30, 2021.

The Organization has a 30-day paydown requirement on the line of credit, which was met for the year ended June 30, 2021.

5. Long-Term Debt

Long-term debt consists of the following as of June 30:

	2021	2020
Note payable, with a local bank (see terms below)	**$ 1,555,131**	$ 1,598,648
Note payable, New Hampshire Health and Education Facilities Authority (NHHEFA), paid in full in July 2020	-	518
Total long-term debt	**1,555,131**	1,599,166
Less current maturities	**52,072**	42,505
Long-term debt, less current maturities	**$ 1,503,059**	$ 1,556,661

The Organization has a promissory note with Citizens Bank, N. A. (Citizens), collateralized by real estate, for $1,670,000 with NHHEFA participating in the lending for $450,000 of the note payable. Monthly payments of $8,011, including interest fixed at 3.05%, are based on a 25 year amortization schedule and are to be paid through April 2026, at which time a balloon payment will be due for the remaining balance.

Scheduled principal repayments of long-term debt for the next five years follows as of June 30:

2022	$ 52,072
2023	49,455
2024	50,882
2025	52,602
2026	1,350,120
Total	$ 1,555,131

The Organization is required to meet an annual minimum working capital and debt service coverage debt covenants as defined in the loan agreement with Citizens. In the event of default, Citizens has the option to terminate the agreement and immediately request payment of the outstanding debt without notice of any kind to the Organization. The Organization was in compliance with all loan covenants at June 30, 2021.

6. Net Assets

Net assets were as follows as of June 30:

	2021	2020
Net assets without donor restrictions		
Undesignated	$ 6,552,445	$ 4,209,982
Designated for working capital	501,837	501,837
Total	$ 7,054,282	$ 4,711,819
Net assets with donor restrictions for specific purpose		
Temporary in nature		
Healthcare and related program services	$ 518,180	$ 389,092
Child health services	165,184	130,429
Total	683,364	519,521
Permanent in nature		
Available to borrow for working capital as needed	101,358	101,358
Total	$ 784,722	$ 620,879

7. Patient Service Revenue

Patient service revenue follows for the years ended June 30:

	2021	2020
Gross charges	$19,234,585	$18,001,613
Less: Contractual adjustments and implicit price concessions	(7,233,156)	(6,697,617)
Sliding fee discount policy adjustments	(2,266,275)	(2,020,443)
Total net direct patient service revenue	9,735,154	9,283,553
Contract 340B program revenue	1,388,710	1,508,541
Total patient service revenue	$11,123,864	$10,792,094

Revenue from Medicaid accounted for approximately 57% and 53% of the Organization's gross patient service revenue for the years ended June 30, 2021 and 2020, respectively. No other individual payor represented more than 10% of the Organization's gross patient service revenue.

8. Retirement Plan

The Organization has a defined contribution plan under Internal Revenue Code Section 403(b) that covers substantially all employees. The Organization contributed $304,497 and $285,796 for the years ended June 30, 2021 and 2020, respectively.

9. Medical Malpractice Insurance

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of June 30, 2021, there were no known malpractice claims outstanding which, in the opinion of management, will be settled for amounts in excess of both FTCA and additional medical malpractice insurance coverage, nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew the additional medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

10. Lease Commitments

The Organization leases office space under noncancelable operating leases. Future minimum lease payments under these lease agreements are as follows:

2022	$ 174,782
2023	141,850
2024	124,676
2025	63,929
Total	$ 505,237

Rent expense amounted to $274,689 and $226,805 for the years ended June 30, 2021 and 2020, respectively.

AMOSKEAG HEALTH BOARD OF DIRECTORS AS OF 5/11/2022

Kathleen Davidson	Board Chair
Christian Scott	Board Vice-Chair
Richard Elwell	Board Treasurer
David Crespo	Board Secretary
Angella Chen-Shadeed	Board Member
David Hildenbrand	Board Member
Dawn McKinney	Board Member
Thomas Lavoie	Board Member
Madhab Gurung	Board Member
Debra (Debbie) Manning	Board Member
Jill Bille	Board Member
Obhed Giri	Board Member
Gail Tudor	Board Member
Rusty Mosca	Board Member

Brett S. Roberts

Professional Summary

Patient-focused Registered Nurse dedicated to the delivery of evidence-based patient care. Confident in collaboration and communication with team members, patients, and their families. Offering clinical knowledge and judgment combined with strong documentation, efficient resource management, and problem-solving abilities. Well-versed in multi-tasking while using excellent organizational and prioritizing skills.

Education

MASTER OF SCIENCE | MCPHS UNIVERSITY | MAY 2023

- Major: Nursing – Family Nurse Practitioner

BACHELOR OF SCIENCE | KEENE STATE COLLEGE | MAY 2020

- Major: Nursing
- Coursework in Adult and Family Health, Maternal Health, Pediatric Health, Community Health, and Psychiatric Health.

Certifications

- Registered Nurse, State of New Hampshire
- Healthcare Provider BLS Certified, American Heart Association

Experience

REGISTERED NURSE COVID-19 MASTER TRAINER| AMOSKEAG HEALTH, MANCHESTER NH | JANUARY 2021 – APRIL 2021

- Collaborate with Nurse Supervisors, Nurse Clinical Managers and the Chief Medical Officer as it relates to staff training, latest evidence-based practice, organizational policies, procedure, processes, and workflows.
- Provide training, support, and resources to clinical support staff on rapidly evolving scientific regulatory advisories and guidance.
- Assist in ongoing review and analysis of staff training and education needs.
- Assist with relevant COVID-19 related clinical improvement opportunities as it relates to review, analysis, troubleshooting, and plan of pandemic response.

REGISTERED NURSE| AMOSKEAG HEALTH, MANCHESTER NH | JUNE 2020 - PRESENT

- Assess patients need for treatment or advice via telephone call or personal encounter.
- Integrate health teaching into daily clinical routine, including appropriate information on health maintenance and disease management for all ages.
- Coordinate patient referrals to other healthcare facilities.
- Actively participate in policy/protocol development for the clinical setting.
- Process prescription refills and necessary vouchers.

- Provide patient care and care coordination for adults with opioid and alcohol use disorder.
- Respond to emergency situations throughout the facility.

MEDICAL ASSISTANT & REGISTERED NURSE| CONVENIENTMD URGENT CARE, KEENE NH | JUNE 2017 – JUNE 2020

- Collaborate with medical and administrative personnel to maintain a patient-focused, engaging and compassionate environment.
- Collect histories, vital signs and current complaints via patient interviews.
- Offer age-appropriate patient care before, during and after exams.
- Complete clinical procedures and gather patient data for interpretation by medical provider.
- Ensure collection of lab specimens by appropriate lab courier.
- Assist medical provider in follow-through of care.
- Perform electrocardiograms, suture removal and dressing changes.
- Cooperated and communicated effectively with medical providers to ensure client satisfaction and compliance with set standards.
- Reviewed client survey information to prioritize areas of improvement.

VALOR STUDENT NURSE TECHNICIAN | U.S. DEPARTMENT OF VETERANS AFFAIRS, WHITE RIVER JUNCTION VT | JUNE 2019-AUGUST 2019

- Deliver safe, evidence based, veteran centered care under direct supervision of BSN-RN preceptor within the Intensive Care Unit.
- Assess patients for any changes in health and/or care status.
- Assess nursing actions for effectiveness in achieving desired outcomes.
- Construct and implement individualized care plans
- Leveraged interpersonal communication strengths to establish rapport and build trust with patients and families.
- Assist with bedside medical procedures. (Ex: Thoracentesis, PICC Line Placement, IJ Placement, & Continuous Renal Replacement Therapy)
- Respond to emergency situations throughout the facility.

LICENSED NURSING ASSISTANT| CHESHIRE MEDICAL CENTER, KEENE NH| JULY 2016 – JUNE 2017

- Comply with all specific guidelines and performed hands-on nursing care to patients under RN supervision.
- Establish relationships with patients, caregivers, and healthcare professionals to promote patients' personal care plan goal achievement.
- Turn and positioned patients to maintain comfort and minimize risk for pressure injury.
- Facilitate activities of daily living, including personal hygiene management, feeding and ambulation.
- Collaborate with interdisciplinary healthcare teams to provide high-quality support to patients.
- Respond appropriately to the physical, emotional, and developmental needs of patients.
- Perform clerical duties, such as word processing, data entry, answering phones and filing.
- Follow and promote protocols and procedures to ensure effectiveness, efficiency and safety.
- Test and record blood glucose levels according to facility policy.

LICENSED NURSING ASSISTANT | LITTLETON REGIONAL HEALTHCARE, LITTLETON NH | JULY 2016 – JANUARY 2020

- Comply with all specific guidelines and performed hands-on nursing care to patients under RN supervision.
- Establish relationships with patients, caregivers, and healthcare professionals to promote patients' personal care plan goal achievement.
- Turn and positioned patients to maintain comfort and minimize risk for pressure injury.
- Facilitate activities of daily living, including personal hygiene management, feeding and ambulation.
- Collaborate with interdisciplinary healthcare teams to provide high-quality support to patients.
- Respond appropriately to the physical, emotional, and developmental needs of patients.
- Perform clerical duties, such as word processing, data entry, answering phones and filing.
- Follow and promote protocols and procedures to ensure effectiveness, efficiency and safety.
- Test and record blood glucose levels according to facility policy.

10-12-12
LM 1125

Christine Groleau

LICENSED PRACTICAL NURSE

LPN with extensive experience working with rehabilition and elderly patients in nursing home setting. Provides quality care, based on high standards of professionalism and compassion. Excellent empathy skills and dedication to patient welfare. Efficient communication with physicians, co-workers and patient families.

- Recording vital signs
- Injections, enemas
- Catheterization
- Wound dressing and management
- Blood draws
- Medication administration
- Personal hygiene and dressing
- Documenting health history
- Clerical duties

PROFESSIONAL EXPERIENCE

Monadnock Community Hospital (2009-2012)

Office Nurse

- Recording patient histories
- Blood and doing other lab tests
- EKGs (electrocardiograms)
- Taking and recording vital signs
- Electronic records
- Prior Autherizing test and medications through insurances
- Changing dressings and performing ordered treatments
- Insurance referals
- Patient teaching
- Lab results
- Telephone and walk in triage
- Phone calls to pharmacists for medication refills
- Phone calls with other health care professionals
- Arranging consults and outside tests

Good Shepherd Healthcare Center (2007 – 2011)

Licensed Practical Nurse

-Recorded condition and nursing requirements of residents.
-Liaised with physicians / administered medication, treatments as prescribed.
-Documented treatment plans and procedures in accordance with regulations.
-Liaised with other nursing departments re patient treatments and therapies.
-Assisted with emergency response to sudden patient illness.
-Hospice care for patient and family.
-Cared for post-surgical patients.
-Assisted residents with self-care techniques.
-Spent quality time with residents, providing compassionate support and understanding.

EDUCATION & LICENSURE

Diploma in Practical Nursing
St.Josephs School of Nursing

[redacted]

License no: PN-014325-22

Caralyn Macek

EDUCATION

Master of Science, Nutrition and Dietetics
Louisiana Tech University, Ruston, LA
August 2012

Dietetic Internship
Louisiana Tech University, Shreveport/Ruston, LA
May 2012

Bachelor of Science, Nutrition and Dietetics
Louisiana Tech University, Ruston, LA
May 2010

CREDENTIALS

Certified as Registered Dietitian by Commission on Dietetic Registration 2012-present
New Hampshire Dietetic Licensure 2013-present

RELEVANT EXPERIENCE

Registered Dietitian
Child Health Services, Manchester, NH — *January 2013- present*
Child Health Services at the Manchester Community Health Center — *November 2014-present*

- Practice as registered dietitian in a pediatric outpatient clinical setting
- Obtain referrals from physicians, nurse practitioners, and physician assistants on staff to address nutritional needs of patients ranging in age from infancy to young adulthood.
- Collaborate effectively with both medical and support staff to ensure highest quality of nutritional care is given to patients referred.
- Provide one-on-one nutrition assessments and interventions with patients and families tailored to patients' individualized needs.
- Document and bill nutrition encounters utilizing EPIC computerized medical records system.

SKILLS/ACCOMPLISHMENTS

Public Health Nutrition Planning

- Responsible for execution of 1 year grant provided to Child Health Services by Anthem BlueCross BlueShield focusing on incorporation of healthy lifestyle changes to improve quality of life for patients and their families. .
- Taught classes at Granite State Independent Living (Manchester, NH) to a group of 20 adolescents focusing on MyPlate, portion control, choosing in-season foods, holiday eating, and preparing easy, healthy recipes at home.
- Responsible for coordination of monthly NH WIC program site visits at Child Health Services to provide needed services to eligible families

Public Relations/Communications

- Participated in National Dance Day Flash Mob at Veterans Park (Manchester, NH) as representative for Child Health Services
- Participated in National Night Out against Crime, One Day of Community, and school health and resource fairs (Manchester, NH) as a representative for Child Health Services and Child Health Services at the Manchester Community Health Center
- Responsible for dietetic interns and nutrition/dietetics students completing school supervision requirements at Child Health Services

Computer

- Proficient in Microsoft Office
- Knowledge of MediTech System, EPIC, Vista/CPRS, Centricity; computerized medical records programs

PROFESSIONAL MEMBERSHIPS

- Academy of Nutrition/Dietetics 2008-present
- New Hampshire Dietetic Association 2013-present

Hamsa Yaseen

CAREER OBJECTIVE

To work full-time with a professional team that offers benefits and room for professional advancement.

SKILLS

- Excellent communication skills, especially in cross-cultural settings
- Extensive Translating Experience
- Fluent in English and Arabic, speak some Spanish
- MS Office Suite, Adobe Photoshop
- Excellent at multitasking under pressure

RELEVANT EXPERIENCE

Geographical Researcher, NOKIA *(The Telecommunications Corporation)* United State
July 2012 – Till Now (Online Employment)

Personal Care Service Provider (PCSP), Regency Nursing Care, LLC Manchester, NH, USA
August 2010 – Till Now

Executive Secretary, The Independent Electoral Commission of Iraq Amman, Jordan
2005-2006

- In conjunction with Deputy Director, staffed and organized the absentee voting offices for Iraqi Parliamentary elections throughout the world
- Ensured the safe passage of sensitive voting data and correspondence between voting centers worldwide
- Translated documents from Arabic – English and English – Arabic as necessary

Accountant, Bank of Baghdad, Head Quarters Baghdad, Iraq
October 1999—September 2001

- Supervised Payroll for HQ using Foxpro software
- Trained new branch accountants on payroll administration
- Tracked all payments to contractors etc.
- Balanced HQ's finances and combined the data with balances from each branch

Table Supervisor/Data Entry Clerk, International Organization for Migration Amman, Jordan
2005

- Supervised a staff of 5 to ensure the proper tabulation of absentee voting of Iraqi Parliamentary Elections
- Responsible for faithfully counting and transmitting sensitive voting data

Free Lance/Accountant, E.M.I.T. Co. (Ercole Marelli Impianti Tecnologici S.p.A.) Amman, Jordan
March 2004—May 2004

- As a Free Lance Translator (English to Arabic – Arabic to English)
- Personal accountant to the project's director

Freelance Translator, Zepter International Amman, Jordan
July 2003—December 2005

- Translated catalogues and technical manuals for Zepter's products from English to Arabic
- Translated training manuals to teach agents to sell Zepter's products

EDUCATION

B.Sc.: Computer Science, Al-Mustansiriya University, College of Education *1999* Baghdad, Iraq

References Available Upon Request

Isa Lara Peguero

SUMMARY

I enjoy working and learning new subjects. Team oriented and hardworking; these have helped bring the best out of any company. I am dedicated, focused, flexible, and organized. These qualities that have been taught by each employer have helped keep a job and maintain a good reference after leaving. Focused on customer satisfaction. I thrive to make a comfortable work environment for the co-workers, with great communication skills and problem solving.

SKILLS

- Cash register operation
- Customer service
- Issue resolution
- Cash drawer balancing
- Training and mentoring
- Payment processing
- Liquor regulations and compliance

EXPERIENCE

Customer Service Cashier

Manchester, NH

Hannaford Bros. Co/ Mar 2020 to Current

- Work closely with front-end staff to assist customers.
- Wrap items and bag purchases properly to prevent merchandise damage.
- Assist customers to find appropriate products, answered product questions and provided product solutions.
- Kept check-out areas clean, organized, and well-stocked to maintain attractive store.
- Processed customer payments quickly, returned exact change, and receipts.
- Observed company return policy when processing refunds, including inspecting merchandise for wear or damage.
- Answered questions about merchandise and demonstrated features of diverse merchandise to facilitate customer sales.
- Cross-trained in cashier, bagger, customer service center, and supervisor roles in order to provide skilled backup for team members.
- Train new employees in cashiering procedures.

Waitress/Bartender

Hooksett, NH

Applebees/ Sep 2015 to Jan 2020

- Attended to all customers quickly to inquire about drinks and start off dining experience with prompt beverage service.
- Applied safe food handling and optimal cleaning strategies to protect customers and maintain proper sanitation.
- Stocked server areas with supplies before, during and after shifts to boost performance of serving staff.
- Addressed any concerns or complaints quickly to improve service and escalated more advanced issues to management for resolution.
- Confirmed customers' ages for alcohol service.
- Discussed menu items and dietary concerns, noted special requests and suggested appetizers or other additional items to meet upsell goals.

- Maximized beverage sales by suggesting appropriate food and drink pairings to suit unique customer preferences.
- Explained preparation of various menu items, describing ingredients and cooking methods to customers.
- Maximized team performance by training new employees on proper food handling, guest expectations and restaurant protocols.
- Recorded orders and partnered with team members to efficiently serve food and beverages.
- Transported all dirty glassware and utensils from dining room to dishwashing area for proper cleaning.
- Educated guests on daily specials and menu offerings such as appetizers, entrees and desserts.

Vehicle Mechanic

Hooksett, NH

Merchants Auto/ Sep 2014 to Sep 2017

- Ordered parts to maintain inventory levels while decreasing wait times on repairs.
- Operated electrical diagnostics equipment to troubleshoot problems in vehicle engines, electrical systems and suspension
- Performed routine maintenance changing oil, checking batteries and lubricating equipment and machinery.
- Followed schedule guidelines for maintenance, determined my mileage.
- Collaborated on repairs to complete and finish work orders on schedule.
- Assessed tread depth and discussed safety levels with customers.
- Completed standard inspections to assess wear and damage to vehicles.

Sales Associate

Manchester, NH

Bath&Body Works/ Apr 2013 to Nov 2013

- Maintained knowledge of current promotions, exchange guidelines, payment policies and security practices.
- Answered incoming telephone calls to provide information about products, services, store hours, policies and promotions.
- Arranged new merchandise with signage and appealing displays to encourage customer sales and move overstock items.
- Kept apprised of emerging trends and provided informative customer service to assist in product selection.
- Collaborated with fellow sales team members to achieve group targets.
- Built and maintained effective relationships with peers and upper management to drive team success toward common sales, service and operational goals.
- Offered product and service consultations and employed upselling techniques.
- Sold various products by explaining unique features and educating customers on proper application.

Machine Operator

Manchester, NH

Summit Packaging Inc./ May 2013 to May 2013

- Detected work-piece defects and machine malfunctions, maintaining machines to prevent future malfunctions.
- Executed on-time, under-budget project management by separating damaged aerosol can caps from the non damaged cans.

EDUCATION AND TRAINING

High School Diploma
Manchester Central High School Jun 2013
Manchester, NH

Some College (No Degree)
Manchester Community College
Manchester, NH

JENNY BRANSON

REGISTERED NURSE

LICENSES, CERTIFICATIONS, TRAININGS

- WHNP-BC, NH (APPLICATION IN PROCESS)
- NCC CERTIFICATION, 104107064 (EXP 12/15/2024)
- RN, NH 083652-21 (EXP 03/04/22)
- SANE AND DVNE (01/18/2020)
- NEXPLANON (10/27/2021)
- BLS (EXP 06/2023)
- AWHONN FETAL HEART MONITORING (06/2021)

EDUCATION

Frontier Nursing University

Graduated September 2021

MSN, Women's Health Nurse Practitioner

Summa Cum Laude

OU Health Sciences Center

Graduated May 2008

Bachelor of Science in Nursing

Graduated with Distinction

Central Carolina Technical College

Graduated August 2003

Associate Degree in Nursing

Departmental Achievement Award

PROFESSIONAL EXPERIENCE

Women's Health Nurse Practitioner Clinical Experience

March – September 2021, 678 hours, 700 visits

Family Medical and Maternity Care (Leominster, MA)

425 hours, 483 visits

Primary care, wellness visits (annual and GYN), gynecologic care, low risk obstetrics, postpartum, family planning, peri/postmenopausal care

Coös County Family Health Services (Berlin, NH)

129.5 hours, 123 visits

Primary care, wellness visits (GYN), gynecologic care, low risk obstetrics, family planning, peri/postmenopausal care

Wellness for Women (Kennebunk, ME)

58.5 hours, 75 visits

Wellness visits (GYN), gynecologic care, family planning, peri/postmenopausal care

South Central COVID Response Team (New Hampshire)

2021

Registered Nurse

Volunteer vaccinator in state-wide COVID vaccination clinics

Women's Resource Center (Norman, Oklahoma)

2019-2020

Sexual Assault Nurse Examiner, Domestic Violence Nurse Examiner

On call provider for survivors of sexual assault and intimate partner violence

Prenatal Diagnostic Center (OU Physicians, Oklahoma City, OK)

2017-2019

Lead Clinical Nurse II, High-Risk OB

- Lead Nurse, supervisor of RN/MA staff, collaborated with Lead Sonographer and Office Manager to ensure engaged employees and a successful clinic
- Provided outpatient nursing care for people with high-risk pregnancies throughout the course of their pregnancy and for 6 weeks postpartum
- Responsible for phone triage, administrative duties, and communication with insurance, labs, pharmacies, and state health departments
- Trained new employees, ordered supplies, organized holiday parties and events, created and maintained morale and informational boards

REFERENCES

Amanda Molter, CNM
Family Medical and Maternity Care
87 N. Main St.
Leominster, MA 01453
978.534.8701

Colleen Monks, Lead Emergency Preparedness Coordinator
South Central Public Health Network
Derry, NH 03038
603.421.2323

Jessica Collett BSN, SANE-A
Women's Resource Center
Norman, OK
405.701.5550

Brandee Ingram, Clinic Administrator
OU Physicians, Prenatal Diagnostic Center
1200 Children's Avenue, Ste 1A
Oklahoma City, OK 73104
405.271.5400

Kaely Jackson, CDE, RD/LD
OU Physicians, Prenatal Diagnostic Center
1200 Children's Avenue, Ste 1A
Oklahoma City, OK 73104
405.271.5400

Kate McCracken, DNP, APRN, CNP
OU Physicians, Prenatal Diagnostic Center
1200 Children's Avenue, Ste 1A
Oklahoma City, OK 73104
405.271.5400

Participated in leadership meetings, the education committee, and OB Emergency Department committee

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Jimmy Everest Center (OU Physicians, Oklahoma City, OK)
2016-2017
Clinical Research Nurse I, Pediatric Oncology

- Key study personnel, responsible for maintaining study documentation for three major facilities
- Responsible for recruiting participants, maintaining communication with participants, and providing educational sessions

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WIC Overseas Program (USAG Schinnen, the Netherlands)
2012-2014
Registered Nurse, Office Manager

- Responsible for delivering the WIC Overseas program to eligible families stationed in the Netherlands, eastern Belgium, and western Germany
- Performed nutrition screenings and provided nutrition education for children ages 0 to 5 and pregnant, breastfeeding, and postpartum people
- Scheduled and taught community health education
- Responsible for marketing within the various communities and countries

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Choctaw-Nicoma Park Public Schools (Choctaw, Oklahoma)
2009-2010
School Nurse

- Responsible for approximately 1,400 students at three elementary schools
- Provided daily medical care of staff and students to include routine screenings, medication administration, chronic disease management, and first aid in both emergent and non-emergent situations
- Created, scheduled, and taught health education for students and staff

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OU Medical Center (Oklahoma City, Oklahoma)
2006-2009
Staff Registered Nurse, Charge Nurse

- RN on Mother-Baby Unit, Level II Nursery, Antepartum
- Trained new employees and nursing students, acted as charge nurse on Mother-Baby Unit

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Sharp Mary Birch Hospital for Women (San Diego, CA)
2003-2004
Staff Registered Nurse

- RN on inpatient Mother-Baby/GYN Unit
- Responsible for couplet care, lactation education, care of women following gynecological procedures

Judi Gleason

[redacted]

[redacted]

I have been working in a pediatric office since October of 2006 and I would now like to be an RN in a more hands on setting. I have been responsible for all aspects of a pediatric office, and feel I am qualified to change positions.

WORK HISTORY

Oct. 2006 – June 2016 *RN, Concord Pediatrics, Concord, NH*

- Nurse Visits
- Injections
- Phone Triage
- Immunizations
- Assist Providers with Procedures
- Record Keeping
- Lab Testing (urinalysis, pregnancy, rapid strep, etc.)
- Prior Authorizations
- Prescription Refills
- Appointment Scheduling
- Vital Sign Monitoring
- Suture and Staple removal
- Wound Care and Dressing Changes
- Nebulizer Treatments

March 1999 – August 2006 *RN, Dartmouth Hitchcock Clinic*

- Injections
- Phone Triage
- Immunizations
- Assist Providers with Procedures
- Record Keeping
- Lab Testing
- Appointment Scheduling
- Vital Sign Monitoring
- Call Patients with Results of Testing and/or Medication Changes per Primary Care Orders

EDUCATION

1990 - 1993 NHTI – Graduated as an RN

1985 – 1987 Mount Ida College – Associated Degree in Science

1981 - 1985 Brewster Academy – Graduated General Studies

→ PA-H selected for 1st

Kristin R. Fossum

[redacted]

OBJECTIVE: To provide quality social services and educational tools to empower children and families

EDUCATION:

New Hampshire Community Technical College
15 Early Childhood Education Credits

University of New Hampshire, Durham, NH
Bachelor of Science: Child and Family Studies- May 2001

University of New Hampshire, Durham, NH
Bachelor of Science: Nursing- May 1999

- Clinical Experience in mental health, community health, med/surg, labor and delivery and oncology nursing
- Obtained registered nurse license in August 1999

worked as nurse? medical setting? children vs parents

WORK EXPERIENCE:

KinderCare Learning Center, Merrimack, NH
Pre-Kindergarten Teacher March 2005-Present

- Responsible for implementing and supplementing curriculum to encourage and challenge multi-age children
- Responsible for daily classroom management and parent communication
- Oversee the Kelsey's Learning Adventures and ABC Music and Me programs as the program leader

VNA Child Care Center, Manchester, NH
Lead Kindergarten Teacher January 2001-December 2005
Associate Kindergarten Teacher September 2001-December 2001

- Educated children of varying cognitive levels and physical abilities by planning and implementing curriculum.
- Positively motivated children with varying behavioral and emotional challenges to become enthusiastic members of the classroom environment.
- Encouraged creativity and arts exploration through various classroom activities.
- Served as classroom representative for IEP and various testing result meetings.

- Increased awareness of health and social support networks by referring families in need to nurse/family resource coordinator.

Families First of The Greater Seacoast, Portsmouth, NH
Family and Child Studies Student Intern September 2000- May 2001

- Enhanced parental knowledge of child growth and development by aiding in the organization of a Babytime parenting group.
- Responsible for the child care for the Single Parents Support Group.
- Provided post partum support and infant development education through home-visiting for three months to one area mother.
- Shadowed prenatal post partum home visitor for entire course of study.

KAITLIN GIRARD

SUMMARY

Self-motivated and compassionate RN, BSN with a passion for patient education and empowerment. Experience delivering culturally competent, patient-centered care in acute care and community settings.

EDUCATION

Massachusetts College of Pharmacy and Health Sciences, Manchester, NH **May 2016**
Bachelor of Science in Nursing
Honors: *cum laude*

University of New Hampshire, Durham, NH **May 2010**
Bachelor of Arts in Theatre: Dance

LICENSURE/CERTIFICATIONS

- American Heart Association BLS (CPR and AED), March 2021
- NCLEX-RN, May 2016

PROFESSIONAL EXPERIENCE

VNA of Manchester and Southern NH **June 2019 – August 2020**
Nurse Case Manager

- In the homecare setting, manage and provide patient/caregiver education surrounding prescribed medications, urinary catheters, ostomies, enteral nutrition, simple to complex wound care and any diagnosed disease process
- Perform venipunctures for lab work as ordered
- Empower patients/caregivers through education and motivational interviewing to reduce risk of hospitalization and promote independence
- Collaborate with PCP, specialists, interdisciplinary and ancillary care team to develop plan of care and ensure compliance/continuity of care

Lowell Community Health Center, Lowell, MA **June 2017 – June 2019**
Charge Nurse, OB/Family Planning, January 2018 – June 2019

- Carry out all clinical nurse duties and deliver culturally sensitive, trauma-informed care to diverse and at-risk patient populations
- Conduct employee performance evaluations
- Precept nursing students and train new employees
- Participate in daily interdepartmental huddles to ensure adequate staffing throughout health center and information dissemination among staff
- Lead and execute quality improvement strategies, monitor for HRSA and Joint Commission compliance and ensure clinical staff competencies

Clinical Nurse, OB/Family Planning, June 2017 – June 2019

- Care coordination, tracking and monitoring for high-risk OB patients. Participate in weekly rounds to collaborate with providers and interdisciplinary care team.
- Assist with IUD and Nexplanon insertions/removals, colposcopies, LEEPs, initial conception counseling
- Perform prenatal intakes, contraception counseling, non-stress tests after completion of AWHONN fetal monitoring course, STD treatment and counseling, Depo-Provera and progesterone injections, diabetes education, telephone and walk-in triage, management of daily nurse visit schedule
- Connect patients to health center and community resources as needed

Elliot Hospital, Manchester, NH **July 2016 – May 2017**

Clinical Nurse, Fitch Unit

- Provide care to inpatients on 44-bed unit with medical and oncology diagnoses
- Perform IV management, blood product administration, tracheostomy, urinary catheter, wound and end-of-life care, parenteral and enteral nutrition, safe IV/PO/IM/SC medication administration
- Respond promptly to changes in condition while collaborating with care team
- Assume care for all patients on unit to aid colleagues and maintain a safe and patient-centered environment

Nihada Ramic

PROFILE

Accomplished, hard-working highly analytical and technically skilled professional with proven ability to maintain precise records, known for accuracy and attention to detail, seeking to obtain a permanent position with a well reputable company to expand knowledge and grow professionally. Excellent organizational and problem-solving skills; motivated, passionate and very enthusiastic when taking on new challenges.

OPERATIONS AND TECHNICAL EXPERIENCE

PERFECT FIT INDUSTRIES LLC.

Logistics Coordinator/Administrative Assistant/Group Leader **2013 – 2016**

- Efficient, organized and detail-oriented
- Computer literate and proficient in Microsoft Office as well as company programs.
- Enthusiastic and eager to learn
- Resourceful, dependable and effective in multitasking
- Discreet and ethical
- Strong analytical and problem solving skills
- Proven leadership skills resulting in quality production and maintaining a positive work environment
- Able to maintain records, and perform other administrative duties
- Outstanding oral and written communication skills

Tasks Included: Scheduling and managing shipments; collaborating with third parties and ensuring company meets all necessary vendor guidelines as well as preparing corresponding billing documents.

CONNECTICUT MULTISPECIALTY GROUP

Accounting Assistant (Medical Billing) **2005 – 2009**

- Able to monitor and administer numerous customer accounts
- Investigate and resolve billing and account discrepancies
- Manage and resolve customer inquiries
- Ability to prioritize tasks and ensure projects are completed in a timely manner
- Strong data entry skills

EDUCATION

SAINT JOSEPH COLLEGE, WEST HARTFORD, CT

Bachelor of Arts in International Studies (Magna Cum Laude) **May 2010**
Concentration: Economy, History and Polity

CITY UNIVERSITY, LONDON, UNITED KINGDOM

Study Abroad **May-July 2009**

TOOLS / SKILLS: Microsoft Office Suite: MS Word, MS PowerPoint, MS Excel and Other Programs
LANGUAGE: Proficient in Bosnian, German, and working knowledge of Spanish

REFERENCES:

WORK REFERENCES:

Adrienne Gelinas (Supervisor, Perfect Fit Industries LLC.) [redacted]
Jennifer Cavanaugh (Manager, Perfect Fit Industries LLC.) [redacted]
Kenneth Boranian (Manager, Perfect Fit Industries LLC.) [redacted]
Sakina Ghouita (Co-worker, Perfect Fit Industries LLC.) [redacted]

EDUCATION REFERENCES:

Dr. Shyamala Raman (University of Saint Joseph) [redacted]

PERSONAL REFERENCES:

Mirela Grebic [redacted]
Almira Zukanovic [redacted]

RAHIMA IBRAHIMOVIC

EDUCATION

1988	Medical school	Zvornik,Bosnia
	❖ **Diploma**	
1999	CNA	Manchester NH
	❖ License **020305-24**	Expires **07/01/2003**
2001	Phlebotomy course	Manchester NH
	❖ **Phlebotomist**	course but only worked phlebotomy in Bosnia

PROFESSIONAL EXPERIENCE

1988 - 1999	Hospital	Bosnia
	❖ **Nurse**	
1999 - 2000	Maple Leaf	Manchester NH
	❖ **CNA**	
2000 - 2001	St.Teresa's Manor	Manchester NH
	❖ **CNA**	

6 mos.

I have a lot of experience on medical field. I am a good worker. Please fill free to contact any of these employers that I worked with for any questions regarding to my work and other issues you may have.

Thank you,

Wednesday, July 18, 2001

Rahima Ibrahimovic

Sandra Bryant

Objective

Provide nutrition and breastfeeding education to the public as an active member of a health care team via quality counseling skills.

Work experience

[2002-present] Southern NH Services WIC Program
Manchester, NH

Breastfeeding Coordinator/ Lactation Consultant/Nutritionist

- Oversee Breastfeeding Peer Counselor support program
- Offer monthly breastfeeding support groups for prenatal women.
- Network with local hospital/community breastfeeding advocates to facilitate breastfeeding support services
- Organize annual World Breastfeeding Day events
- Offer quality nutritional and breastfeeding education services.

[2002-present] Manchester Community Health Center
Manchester, NH

Nutritionist

* Offer counseling and support services of diabetic, hyperlipidemia, prenatals and weight loss patients.
* Provide individual follow up care as needed.
* Referrals to community service programs.

[1998-1999] PCHC WIC Program
Providence, RI

Program Nutritionist/Lactation Consultant

- Provide continuity of care via breastfeeding counseling support services for nursing women.
- Supervision of Program Assistant staff.
- Asses nutritional needs of mothers, infants and children of all cultures.

[1993-1998] Taunton/Attleboro WIC Program
Taunton, MA

WIC Nutritionist/Breastfeeding Coordinator

- Conduct nutrition assessment and certification of WIC Clients.
- \production of monthly newsletter.
- Coordinator of monthly breastfeeding support groups.

Education [1988-1992] University of Rhode Island Kingston, RI

- B.A., Food Science and Nutrition

Accreditations LDN- Licensed Dietitian Nutritionist 1994

IBCLC- International Board Certified Lactation Consultant 1995.

Cornell

VIVIAN VELEZ

5

OBJECTIVE

Seeking a responsible and challenging position that will utilize my skills as well as give me the opportunity to expand and acquire new skills within the company.

EXPERIENCE

09/2002-11/02 — Nashua School District SAU #42 — Nashua, NH

SPED Secretary

Provide secretarial support to the SpeciaLEd Department. My responsibilities consist of Data entry, filing, run reports for Director, mail out compliance letters, Update OOD roster and distribute updates. Maintain balance of the yearly Special Ed budget. Match incoming invoices to be paid give to accounting. Send out memos to all schools to request case management. Send go-back sheets to the teachers for Spedis corrections.

01/2002-09/2002 — New Hampshire Legal Assistance — Manchester, NH

FHP / Intake Coordinator, Administrative Assistant

Provide secretarial administrative support to the FHP team as well as participate in FHP case reviews. Handle all FH intakes. Attend conferences sponsored by HUD Northeast Regional office. My duties also include pend / distribute & re-file case folders, Greet visitors / clients, Interview potential clients & determine whether eligible for area, case type & income via phone or walk-in, Refer to other agencies, Answer Phone, monitor voice mail & field calls to advocates and/or callbacks, Process /sort mail, Transcribe/type letter, memos, Legal docs from Dictaphone or longhand notes, Copy documents, Translate written materials (English to Spanish) Interpret for Spanish-speaking clients in office & court, Open files, promptly; process closed files; closed intakes, prepare conflict reports and fax to other Branch offices. Copy materials for advocates, Monitor ,order pamphlet supply, File all FHP materials, Courier services to other offices & courts, Assist with miscellaneous task.

09/2001-01/2002 — Manchester Comm. Health Center — Manchester, NH

Spanish Interpreter

Provide direct services of translation of information (i.e., verbal or written adequately and accurately to clients. Assist clients to obtain necessary information from other agencies. Provide necessary coverage for Spanish/English translation. Translate documents from (English to Spanish) Demonstrate sensitivity to the cultural diversity of population being served. Increase quality of access to health care for minorities by assisting the Health Educator in evaluating culturally appropriate health education materials. Extra duties helping front desk (i.e. Patient accounts, scheduling appt, re-scheduling, canceling, data entry, answer phone etc.,)

03/2001-04/2001 — eGCS / Innovative Telecom — Nashua, NH

Office Manager

Work directly for the CEO, Issue Pagers/ Mobile phones to employees that require the tool. Deal with company vendors on a daily basis. Purchased company products for internal use. Suggested ways to improve cost reduction. Transcribe prompts, set up payroll for week endings. Make travel and lodging arrangements for onsite employees as well as for visiting clients. Assisted Human Resource manager on a daily basis; Filing, Answer phones.

06/2000-03/2001 — eGCS / InnovativeTelecom — Nashua, NH

Program Manager

Implementation and development of the Prepaid Post paid and Pos Phone Card Services transaction, processing for major local providers consuming ten to 30 million minutes a month. Dealing with clients on a daily basis regarding new software and hardware enhancements for their services, product releases, technical issues, billing issues, matrix, and reporting contract agreements.

Distributing product implementation to several departments (i.e. Engineering, MIS, Customer Service, and Tech Support). Responsible for monthly account Matrix presentations. Assisting Account Manager on master planning for account evaluations, expansions and migrations. Maintaining accurate spreadsheets containing product information. Created an implementation process that increased programs releases deadline 100%. Required to assist on client's weekly conference calls as well as departmental meetings.

06/1999-06/2000 eGCS / Innovative Telecom Nashua, NH
Administrative Manager/Marketing

Maintained and updated Standard Service Descriptions (SSDs) (including call flows), User Manuals, and feature sets including updates based upon ongoing service revisions and enhancements. Maintained revision Directory and Service Archive. Ensured accessibility to Revision Directory for Program Management and Product Management. Provided current copies, as needed to remote Sales and Account Management. Assisted in testing new Standard Service Offerings, and in testing revisions and enhancements to existing Service Offerings; document findings. Order Business cards, Translate required documents to Spanish.

06/1997-06/1999 Innovative Telecom Nashua, NH
Account Specialist

Specialized on one specific account, Maintained books, Account Payables/Receivables and Aging Reports. Approved Credit line increases on Retailers as well as declining any orders for collection issues/ fraud etc. Graduated from CORE CORRICULUM

04/1995-06/1997 Innovative Telecom Nashua, NH

Administrative Assistant

In charge of order entry for designated client(s). Entered over 50+ orders a day in Macola. Informed designated client of order increase, pass due accounts, new retailers as well as new hires.

10/1994-04/1995 Innovative Telecom Nashua, NH
Customer Service Representative

Responsible in providing maximum satisfaction to Customer issues. Maintain full knowledge of all queues. Desk side coaching evaluation for better Quality Customer Service. Receiving outbound calls from customers encountering problems with their pre-paid calling card as well as any customer issue.

EDUCATION

September 2002 - present **Manchester, NH**
Manchester Community Tech College
Medical Interpretation Course

February 1998 **Nashua, NH**
Adult Learning Center
Typing and Keyboarding

October1997 **Nashua, NH**
NH Technical College
Computer classes (i.e. Microsoft Word, Office, Excel, PowerPoint, Visio)

June1988 **Brooklyn, NY**
High School - Bushwick High School

REFERENCE:

Furnished upon request.

MANCHESTER COMMUNITY HEALTH CENTER
1415 Elm Street • Manchester, NH 03101 • 603.626.9500

APPLICATION FOR EMPLOYMENT

Assistance in completing this form will be provided to anyone requesting it.
Manchester Community Health Center is an Equal Opportunity Employer in accordance with all applicable laws.

Application must be completed in full. Please Print.

PERSONAL INFORMATION

Position(s) applied for: Interpreter	Date of Application:

Last Name Velasquez	First Name Lizette	Middle Int.
Mailing Address [redacted]		
City [redacted]	State [redacted]	Zip [redacted]
Telephone Number [redacted]	Social Security Number [redacted]	

How did you learn about us? ☐ Advertisement ☐ Friend ☒ Employee Cynthia Diaz (employee's name)

Have you ever been employed here previously? ☒ No ☐ Yes If yes, when _____

AVAILABILITY

☐ Full-Time	☒ Part-Time	Expected Rate of Pay: $_____ ☐ Hourly ☐ Monthly ☐ Annually

IF YOU ARE APPLYING FOR PART-TIME WORK, PLEASE INDICATE HOURS OF AVAILABILITY BELOW:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From _____	From _____	From _____	From _____	From _____	From _____
To _____	To _____	To _____	To _____	To _____	To _____

On what date will you be available for work? Open

Are you under 18 years of age? ☐ Yes ☒ No

Can you legally work in the US? ☒ Yes *(Proof must be provided upon hire.)* ☐ No

EDUCATION

School	Address	Graduation	Degree	Major
High School Name of High School Francisco Rodriguez Lopez	Puerto Rico	☒ Yes ☐ No		
Technical/Business/Professional School		☐ Yes ☐ No Years completed 1 2 3 4		
College/University Cornell University cooperative extension	Certificate Nutrition and Health [redacted]	☐ Yes ☐ No Years completed 2 3 4		
Graduate School		☐ Yes ☐ No Years completed 1 2 3 4		
Honors, Awards, Etc.:				

Professional Registration/License/Accreditation:

State/Type:	Number (if applicable)	Expiration Date:
State/Type:	Number (if applicable)	Expiration Date:

EXPERIENCE

List most recent employer first.

Company/Employer: Cornell University cooperative Extension [redacted]	Employment Dates: 04/1998 to 01/2003 month/year month/year	Job Title: Community Educator Final Wage/Salary $_____ ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving Move to manchester	Duties
City State [redacted] Zip [redacted]	Name of Supervisor Carol Parker Duncanson	Telephone Number [redacted]
Company/Employer: Abacus Communication [redacted]	Employment Dates: 08/18/03 to _____ month/year month/year	Job Title: Telephone services Representative Final Wage/Salary $_____ BiWeekly ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving still working at abacus	Duties
City State [redacted] Zip [redacted]	Name of Supervisor Barbara	Telephone Number [redacted]
Company/Employer:	Employment Dates: _____ to _____ month/year month/year	Job Title: Final Wage/Salary $_____ ☐ weekly ☐ monthly ☐ annually
Address	Reason for Leaving	Duties
City State Zip	Name of Supervisor	Telephone Number

ADDITIONAL INFORMATION

May we request references from your PRESENT employer? ☒ Yes ☐ No	From your FORMER employers? ☒ Yes ☐ No
If NO, please explain:	If NO, please explain:
Have you ever been discharged by an employer? ☐ Yes ☒ No	If YES, please explain:
Have you ever been convicted of a felony? ☐ Yes ☒ No	If YES, please explain:

Please include any additional information you feel would be applicable to your application (attach a separate piece of paper if necessary).

In being considered for employment by Manchester Community Health Center, I agree that the Health Center and any of my employers, except those in which I may have indicated on this form, may exchange information regarding my qualifications without incurring liability.

Employment is subject to the following:

- Satisfactory pre-employment physical examination, following an employment offer
- Satisfactory reference reports
- Willingness to abide by all Health Center requirements and regulations
- Availability of a position for which the applicant is qualified

I certify that the information I have provided on this application (and resume, if applicable) is true and I understand that false statements may be considered grounds for termination. I understand that no contract is made or implied by employment at Manchester Community Health Center or through interpretation of its policies.

Lizette Velasquez
Signature of Applicant

10/13/03
Date

MANCHESTER COMMUNITY HEALTH CENTER

1415 Elm Street • Manchester, NH 03101 • 603.626.9500

APPLICATION FOR EMPLOYMENT

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Application must be completed in full. Please Print.

PERSONAL INFORMATION

Position(s) applied for:	Date of Application:
Medical Assistant	7-14-2010

Last Name	First Name	Middle Int.
Nieves	Tammy	L
Mailing Address [redacted]		
City [redacted]	State [redacted]	Zip [redacted]
Telephone Number [redacted]	Social Security Number [redacted]	

How did you learn about us? ☐ Advertisement ☑ Friend ☐ Employee _____ (employee's name)

Have you ever been employed here previously? ☐ No ☑ Yes If yes, when 1997 - 2004

AVAILABILITY

☑ Full-Time	☑ Part-Time	Expected Rate of Pay: $_____ ☐ Hourly ☐ Monthly ☐ Annually

IF YOU ARE APPLYING FOR PART-TIME WORK, PLEASE INDICATE HOURS OF AVAILABILITY BELOW:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From _____	From _____	From _____	From _____	From _____	From _____
To _____	To _____	To _____	To _____	To _____	To _____

On what date will you be available for work? today

Are you under 18 years of age? ☐ Yes ☒ No

Can you legally work in the US? ☑ Yes *(Proof must be provided upon hire.)* ☐ No

EDUCATION

School	Address	Graduation	Degree	Major
High School Armwood Senior High	[redacted]	☑ Yes ☐ No	Diploma	
Technical/Business/Professional School NH Community Tech	[redacted]	☑ Yes ☐ No Years completed 1 1½ 2 3 4	Diploma	
College/University		☐ Yes ☐ No Years completed 1 2 3 4		
Graduate School		☐ Yes ☐ No Years completed 1 2 3 4		
Honors, Awards, Etc.:				

Professional Registration/License/Accreditation:

State/Type:	Number (if applicable)	Expiration Date:
State/Type:	Number (if applicable)	Expiration Date:

EXPERIENCE

List most recent employer first.

Company/Employer: Martins Point Medical Group, LLC	Employment Dates: 5/05 to 2/2010 month/year month/year	Job Title: Final Wage/Salary $ 16.49 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving	Duties Medical Assistant
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor Dianne Newbury	Telephone Number [redacted]
Company/Employer: Lamprey Health Care	Employment Dates: 8/04 to 2/05 month/year month/year	Job Title: Final Wage/Salary $ 14.00 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving	Duties Medical Assistant
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor	Telephone Number
Company/Employer: MCHC	Employment Dates: 11/97 to 6/04 month/year month/year	Job Title: Final Wage/Salary $ 14.00 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving moved out of the area	Duties Medical Asst.
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor	Telephone Number [redacted]

ADDITIONAL INFORMATION

May we request references from your PRESENT employer? ☐ Yes ☐ No	From your FORMER employers? ☑ Yes ☐ No
If NO, please explain:	If NO, please explain:
Have you ever been discharged by an employer? ☑ Yes ☐ No	If YES, please explain:
Have you ever been convicted of a felony? ☐ Yes ☑ No	If YES, please explain:

Please include any additional information you feel would be applicable to your application (attach a separate piece of paper if necessary).

In being considered for employment by Manchester Community Health Center, I agree that the Health Center and any of my employers, except those in which I may have indicated on this form, may exchange information regarding my qualifications without incurring liability.

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- Satisfactory pre-employment physical examination, following an employment offer
- Satisfactory reference reports
- Willingness to abide by all Health Center requirements and regulations
- Availability of a position for which the applicant is qualified

I certify that the information I have provided on this application (and resume, if applicable) is true and I understand that false statements may be considered grounds for termination. I understand that no contract is made or implied by employment at Manchester Community Health Center or through interpretation of its policies.

Signature of Applicant

7.14.2010
Date

MANCHESTER COMMUNITY HEALTH CENTER
1415 Elm Street • Manchester, NH 03101 • 603.626.9500

APPLICATION FOR EMPLOYMENT

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Manchester Community Health Center is an Equal Opportunity Employer in accordance with all applicable laws.

Application must be completed in full. Please Print.

PERSONAL INFORMATION

Position(s) applied for:	Date of Application:
Medical Assistant	7-14-2010

Last Name	First Name	Middle Int.
Nieves	Tammy	L
Mailing Address [redacted]		
City [redacted]	State [redacted]	Zip [redacted]
Telephone Number [redacted]	Social Security Number [redacted]	

How did you learn about us? ☐ Advertisement ☑ Friend ☐ Employee _____ (employee's name)

Have you ever been employed here previously? ☐ No ☑ Yes If yes, when 1997 - 2004

AVAILABILITY

☑ Full-Time	☑ Part-Time	Expected Rate of Pay: $_____ ☐ Hourly ☐ Monthly ☐ Annually

IF YOU ARE APPLYING FOR PART-TIME WORK, PLEASE INDICATE HOURS OF AVAILABILITY BELOW:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From _____	From _____	From _____	From _____	From _____	From _____
To _____	To _____	To _____	To _____	To _____	To _____

On what date will you be available for work? today

Are you under 18 years of age? ☐ Yes ☒ No

Can you legally work in the US? ☑ Yes *(Proof must be provided upon hire.)* ☐ No

EDUCATION

School	Address	Graduation	Degree	Major
High School Armand Senior High	[redacted]	☑ Yes ☐ No	Diploma	
Technical/Business/Professional School NH Community Tech	[redacted]	☑ Yes ☐ No Years completed 1 1/2 2 3 4	Diploma	
College/University		☐ Yes ☐ No Years completed 1 2 3 4		
Graduate School		☐ Yes ☐ No Years completed 1 2 3 4		
Honors, Awards, Etc.:				

Professional Registration/License/Accreditation:

State/Type:	Number (if applicable)	Expiration Date:
State/Type:	Number (if applicable)	Expiration Date:

EXPERIENCE

List most recent employer first.

Company/Employer: Martins Point Medical Group, LLC	Employment Dates: 5/05 to 2/2010 month/year month/year	Job Title: Final Wage/Salary $ 16.49 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving	Duties Medical Assistant
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor Dianne Newbury	Telephone Number [redacted]
Company/Employer: Lamprey Health Care	Employment Dates: 8/04 to 2/05 month/year month/year	Job Title: Final Wage/Salary $ 14.00 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving	Duties Medical Assistant
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor	Telephone Number
Company/Employer: MCHC	Employment Dates: 11/97 to 6/04 month/year month/year	Job Title: Final Wage/Salary $ 14.00 / hr ☐ weekly ☐ monthly ☐ annually
Address [redacted]	Reason for Leaving moved out of the area	Duties Medical Asst.
City [redacted] State [redacted] Zip [redacted]	Name of Supervisor	Telephone Number [redacted]

ADDITIONAL INFORMATION

May we request references from your PRESENT employer? ☐ Yes ☐ No	From your FORMER employers? ☑ Yes ☐ No
If NO, please explain:	If NO, please explain:
Have you ever been discharged by an employer? ☑ Yes ☐ No	If YES, please explain:
Have you ever been convicted of a felony? ☐ Yes ☑ No	If YES, please explain:

Please include any additional information you feel would be applicable to your application (attach a separate piece of paper if necessary).

In being considered for employment by Manchester Community Health Center, I agree that the Health Center and any of my employers, except those in which I may have indicated on this form, may exchange information regarding my qualifications without incurring liability.

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- Satisfactory reference reports
- Willingness to abide by all Health Center requirements and regulations
- Availability of a position for which the applicant is qualified

I certify that the information I have provided on this application (and resume, if applicable) is true and I understand that false statements may be considered grounds for termination. I understand that no contract is made or implied by employment at Manchester Community Health Center or through interpretation of its policies.

Signature of Applicant

7.14.2010
Date

AMOSKEAG HEALTH

Key Personnel
PRIMARY CARE SERVICES
date of G&C – 6/30/22

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Bryant, Sandra	Nutritionist	$13,180	100%	$13,180
Roberts, Brett	Diabetic Coordinator/Nurse	$17,160	100%	$17,160
Corniell, Vivian	Outreach (MCD) Enrollment Coordinator	$10,681	100%	$10,681
Branson, Jennifer	Prenatal Nurse Coordinator	$17,680	38%	$6,630
Fossum, Kristin	Nurse - Pediatric Care Coordinator	$16,645	38%	$6,242
Girard, Katlin	Perinatal Care Coordination Nurse Perdiem	$5,655	100%	$5,655
Gleason, Judith	Triage Nurse	$12,355	100%	$12,355
Groleau, Christine	Care Coordinator Manager	$16,900	50%	$8,450
Ibrahimovic, Rahima	Immunization Coordinator & Site Manager	$10,774	100%	$10,774
Macek, Caralyn	Nutritionist	$11,220	100%	$11,220
Nieves, Tammy	Medication Asst & Refill Coordinator	$10,187	100%	$10,187
Ramic, Nihada	Interpreter	$4,503	100%	$4,503
Pegureo, Isa	Interpreter	$8,461	60%	$5,076
Yaseen, Hamsa	Interpreter	$8,591	50%	$4,295
Velasquez, Lizette	Language Access Coordinator	$11,700	35%	$4,095
			Total:	**$130,503**

AMOSKEAG HEALTH

Key Personnel
PRIMARY CARE SERVICES
July 1, 2022 - June 30, 2023

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Bryant, Sandra	Nutritionist	$53,506	100%	$53,506
Roberts, Brett	Diabetic Coordinator/Nurse	$69,670	100%	$69,670
Corniell, Vivian	Outreach (MCD) Enrollment Coordinator	$43,364	100%	$43,364
Branson, Jennifer	Prenatal Nurse Coordinator	$71,781	50%	$35,890
Fossum, Kristin	Nurse - Pediatric Care Coordinator	$67,580	50%	$33,790
Girard, Katlin	Perinatal Care Coordination Nurse Perdiem	$22,959	100%	$22,959
Gleason, Judith	Triage Nurse	$50,162	100%	$50,162
Groleau, Christine	Care Coordinator Manager	$68,614	60%	$41,168
Ibrahimovic, Rahima	Immunization Coordinator & Site Manager	$43,744	100%	$43,744
Macek, Caralyn	Nutritionist	$45,554	100%	$45,554
Nieves, Tammy	Medication Asst & Refill Coordinator	$41,358	100%	$41,358
Ramic, Nihada	Interpreter	$18,283	100%	$18,283
Pegureo, Isa	Interpreter	$34,349	60%	$20,610
Yaseen, Hamsa	Interpreter	$34,877	50%	$17,439
Velasquez, Lizette	Language Access Coordinator	$47,502	35%	$16,626
			Total:	**$554,123**

AMOSKEAG HEALTH

Key Personnel
PRIMARY CARE SERVICES
July 1, 2023 - June 30, 2024

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Bryant, Sandra	Nutritionist	$54,309	100%	$54,309
Roberts, Brett	Diabetic Coordinator/Nurse	$70,714	100%	$70,714
Corniell, Vivian	Outreach (MCD) Enrollment Coordinator	$44,015	100%	$44,015
Branson, Jennifer	Prenatal Nurse Coordinator	$72,857	50%	$36,429
Fossum, Kristin	Nurse - Pediatric Care Coordinator	$68,593	48%	$32,582
Girard, Katlin	Perinatal Care Coordination Nurse Perdiem	$23,304	100%	$23,304
Gleason, Judith	Triage Nurse	$50,915	100%	$50,915
Groleau, Christine	Care Coordinator Manager	$69,643	53%	$36,563
Ibrahimovic, Rahima	Immunization Coordinator & Site Manager	$44,400	100%	$44,400
Macek, Caralyn	Nutritionist	$46,238	100%	$46,238
Nieves, Tammy	Medication Asst & Refill Coordinator	$41,979	100%	$41,979
Ramic, Nihada	Interpreter	$18,557	100%	$18,557
Pegureo, Isa	Interpreter	$34,864	60%	$20,919
Yaseen, Hamsa	Interpreter	$35,400	50%	$17,700
Velasquez, Lizette	Language Access Coordinator	$48,215	33%	$15,670
			Total:	**$554,294**

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-03)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Concord Hospital, Inc.		1.4 Contractor Address 250 Pleasant St. Concord, NH 03301	
1.5 Contractor Phone Number (603) 230-6057	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $658,569
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Robert Steigmeyer 8DD5DBFF8EA8420... Date: 5/20/2022		1.12 Name and Title of Contractor Signatory Robert Steigmeyer President and CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt D778BB63F9704C7... Date: 5/23/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Takhmina Rakhmatova FDF521C025C24AC... On: 5/31/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials DS RS
Date 5/20/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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Date 5/20/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referral for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Increase number of Postpartum Women who Have Lactation Support, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): To Measure the Percentage of Adolescents Screened for Substance Use, in accordance with Attachment #4, and

1.12.2. QI Project Two (2): Adolescents who Received a Brief Intervention or Referral to Services upon a Positive Substance Test, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

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license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Concord Hospital Family Health Center*

Budget Request for: *Maternal & Child Health Care in Integrated Primary Care Setting*

Budget Period *SFY 2022 (Date of G & C - 6/30/2022); Form Completed 4/21/2022, revised 5/10/22*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$18,143
2. Fringe Benefits	$5,805
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)- Patient Revenue (removed from total cost)	$0
Other (please specify)- Non-Salary Expense in Cost Centers	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$23,948
Total Indirect Costs	$2,395
TOTAL	**$26,343**

DS RS

Contractor Initials

5/20/2022

Date

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Concord Hospital Family Health Center*

Budget Request for: *Maternal & Child Health Care in Integrated Primary Care Setting*

Budget Period *SFY 2023; Form Completed 4/18/2022, revised 5/10/22*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$217,709
2. Fringe Benefits	$69,666
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)- Patient Revenue (removed from total cost)	$0
Other (please specify)- Non-Salary Expense in Cost Centers	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$287,375
Total Indirect Costs	$28,738
TOTAL	**$316,113**

DS
RS
Contractor Initials

5/20/2022
Date

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Concord Hospital Family Health Center*
Budget Request for:	*Maternal & Child Health Care in Integrated Primary Care Setting*
Budget Period	*SFY 2024; Form Completed 4/18/2022, revised 5/10/22*
Indirect Cost Rate (if applicable)	10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$217,709
2. Fringe Benefits	$69,667
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)- Patient Revenue (removed from total cost)	$0
Other (please specify)- Non-Salary Expense in Cost Centers	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$287,376
Total Indirect Costs	$28,738
TOTAL	**$316,113**

DS
RS
5/20/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

Vendor Initials RS (DS)
Date 5/20/2022

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

DocuSigned by:
Robert Steigmeyer
6BB5BDFF0EA0428...

5/20/2022
Date

Name: Robert Steigmeyer
Title: President and CEO

New Hampshire Department of Health and Human Services
Exhibit E

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/20/2022
Date

DocuSigned by:
Robert Steigmeyer
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Name: Robert Steigmeyer
Title: President and CEO

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

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Contractor Initials _____

5/20/2022
Date _____

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/20/2022
Date

DocuSigned by:
Robert Steigmeyer
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Name: Robert Steigmeyer
Title: President and CEO

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RS
Contractor Initials

5/20/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

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RS
Contractor Initials _____

Date 5/20/2022

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

5/20/2022
Date

DocuSigned by:
Robert Steigmeyer
8DD3D6FF6EA8426...
Name: Robert Steigmeyer
Title: President and CEO

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Robert Steigmeyer

5/20/2022
Date

Name: Robert Steigmeyer
Title: President and CEO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Concord Hospital
The State by:	Name of the Contractor
Iain Watt	Robert Steigmeyer
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Robert Steigmeyer
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	President and CEO
Title of Authorized Representative	Title of Authorized Representative
5/23/2022	5/20/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Robert Steigmeyer

5/20/2022
Date

Name: Robert Steigmeyer
Title: President and CEO

Contractor Initials RS
Date 5/20/2022

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 073977399

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

DS RS
Contractor Initials _____
Date 5/20/2022

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening for Referrals for SDOH

Enabling Services Workplan
Agency Name: Concord Hospital Family Health Center
Name and Role of Person(s) Completing Work Plan: Sarah Kelly, Administrative Director and Sarah Healey, Clinical Manager

Enabling Services Focus Area: Focus on screening and referrals for Social Determinants of Health (SDOH)

Project Goal: Increase identification of patients who have identified needs related to *Community, Safety and Social Context* and increase referrals to community resources.

Project Objective: Ensure screening for exposure to violence/trauma occurs at more than 50% annual wellness visits (well child visits, annual physicals, Medicare wellness visits) at the Family Health Center(s), and for those patients who screen positive a referral to behavioral health is made.

Activities (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Identify baseline measure of screening for exposure to violence/trauma at annual wellness visits.	Reporting / Data Analyst	Establish a baseline, identify any areas of higher need.	April-May 2022
Training for clinical staff (MA's and RN's) occur to ensure screening questions are asked and documented at all wellness visits. Include Integrated Behavioral Health Care Specialists (IBHCs) in training to normalize asking sensitive questions, facilitate referrals and resource gathering.	Clinical Manager Clinical Leader Resource Nurses Registered Nurses Medical Assistants Behavioral Health Manager Clinical Manager IBHC Team Clinical Team Concord Hospital Community Health Coordinator	Confirm attendance at training session (or 1:1 after session) occurs for all clinical staff. Will be measured by sign in sheet.	May 2022-July 2022
Monitor percentage of annual wellness visits where screening is documented and referrals made as needed.	Data Analyst Clinical Leader Resource Nurses	For any staff member not meeting or exceeding the 50% screening rate at annual wellness visits, Clinical Leader or Resource Nurse will provide additional training and support.	August 2022-January 2023

Contractor Initials RS
Date 5/20/2022

Attachment #2 – Increase Number of Postpartum Women Who Have Lactation Support

Enabling Services Workplan Agency Name: Concord Hospital Family Health Center Name and Role of Person(s) Completing Work Plan: Sarah Kelly, Administrative Director and Sarah Healey, Clinical Manager			
Enabling Services Focus Area: Increase number of postpartum women who have lactation support			
Project Goal: Increase lactation supports for patients at the CH-FHC (Concord and Hillsboro) to continue to reinforce and facilitate baby-friendly activities in the ambulatory setting.			
Project Objective: Increase lactation support from __% to ___%			
Activities (list as many activities as are planned to reach the Objective)	**Staff/Resources Involved (list for each activity)**	**Evaluation Plans (list as needed for each activity)**	**Timeline for Activity (estimated timeline for the duration of each activity)**
Certify Breastfeeding Counselor (Cost: $450/nurse) 2 day course and exam	Registered Nurse – Concord (OB Nurse Coordinator) Registered Nurse – Hillsboro	Completion of course, pass exam and can share information with others.	May 2022 – July 2022
Develop a list of postpartum mothers to facilitate awareness of patients in the clinic(s) that could potentially be breastfeeding.	Data analyst and Reporting team OB Nurse Coordinator	Completion of a patient list to be used internally for identification of postpartum mothers.	June 2022-July 2022
Ensuring documentation of support for breastfeeding is captured in a reportable format and train all nursing staff at the Family Health Centers (Concord and Hillsboro) on how to document this information.	Clinical Manager OB Nurse Coordinator Resource Nurses Registered Nurses	Confirmation that training has occurred and manually audit/monitor documentation for postpartum mothers coming to the FHC Concord or Hillsboro.	August 2022-January 2023
Coordination with Concord Hospital community to ensure breastfeeding support is available at the Family Health Centers (Concord and Hillsboro)	Clinical Manager OB Nurse Coordinator Family Place at Concord Hospital OB Providers at CH/CHMG Public Affairs Department	Attendance at team or department meetings. Social media or online advertising, as approved by CH Public Affairs.	August 2022-January 2023
Review handouts that are provided to postpartum mothers in standard packets that are	Clinical Manager OB Nurse Coordinator	Ensure lactation support documentation is available in packets given to patients.	October 2022-January 2023

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Attachment #2 – Increase Number of Postpartum Women Who Have Lactation Support

currently being distributed, add documentation regarding the support options that are available through the Family Health Center.			

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 (July 1, 2023 – June 30, 2024)	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4

Quality Improvement Work Plan and Progress Report

Quality Improvement Work Plan Agency Name: Concord Hospital Family Health Center Name and Role of Person(s) Completing Work Plan: Sarah Kelly, Administrative Director and Sarah Healey, Clinical Manager			
MCH Performance Measure: To be designated by the Department on Adolescent Well Visits for SFY 2022-2024			
Project Objective: Increase the percentage of adolescents aged 12-21 who have one comprehensive well-care visit or physical exam during the measurement year.			
Activities (list as many activities as are planned to reach the Objective)	**Staff/Resources Involved (list for each activity)**	**Evaluation Plans (list as needed for each activity)**	**Timeline for Activity (estimated timeline for the duration of each activity)**
Identify current percentage of adolescents (ages 12-21) who have a comprehensive well-care visit or physical exam during a calendar year.	Data analyst	Assess current state of adolescent well visits.	April-May 2022
Interview clinicians to identify any known barriers to adolescents receiving wellness visits on an annual basis	Clinical Manager Practice Managers Anchor Faculty Physicians Resource Nurses Integrated Behavioral Health Clinicians	Document any known barriers to adolescents receiving well visits and strategize on how FHC/FMR can mitigate any known barriers.	May-July 2022
Implementation of any mitigation strategies as identified through clinician interviews.	Clinical Manager Practice Managers Anchor Faculty Physicians Resource Nurses Integrated Behavioral Health Clinicians	For each mitigation strategy, the team will identify the issue and proposed resolution.	June-August 2022
Review measurement of current percentage of adolescents (ages 12-21) who have had their well visit OR are scheduled for a well visit in the upcoming year.	Data Analyst Clinical Manager Practice Manager	Identify if processes have improved the scheduling and/or performance of well visits.	July 2022-December 2022

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Attachment #5 - Adolescents Who Received a Brief Intervention or Referral to Services upon a Positive Substance Test (NH MCHS)

Quality Improvement Work Plan Agency Name: Concord Hospital Family Health Center Name and Role of Person(s) Completing Work Plan: Sarah Kelly, Administrative Director and Sarah Healey, Clinical Manager			
MCH Performance Measure: To be designated by the Department on Adolescent Well Visits for SFY 2022-2024			
Project Objective:			
Activities (list as many activities as are planned to reach the Objective)	**Staff/Resources Involved (list for each activity)**	**Evaluation Plans (list as needed for each activity)**	**Timeline for Activity (estimated timeline for the duration of each activity)**

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Quality Improvement Work Plan

Agency Name: Concord Hospital Family Health Center

Name and Role of Person(s) Completing Work Plan: Sarah Kelly, Administrative Director and Sarah Healey, Clinical Manager

MCH Performance Measure: Adolescent Measure: SBIRT – Percentage of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

Project Objective: Improve screening rates for adolescents are screened for substance use utilizing the SBIRT intervention process by 10%.

Activities (list as many activities as are planned to reach the Objective)	**Staff/Resources Involved (list for each activity)**	**Evaluation Plans (list as needed for each activity)**	**Timeline for Activity (estimated timeline for the duration of each activity)**
Identify baseline measure of SBIRT screening for adolescents aged 12-17 at CH-FHC.	Data Analyst	Review report to establish baseline measures. Use data to inform if there are specific visit types where SBIRT screening is not occurring for adolescents.	April-May 2022
Work with the clinical team to identify barriers to adolescent SBIRT completion, including parental involvement and keeping information protected for positive adolescent screening.	Clinical Manager Clinical Leader Concord Hospital Health Information Management Department and Release of Information Medical Director Behavioral Health Manager Integrated Behavioral Health Clinicians	Develop protocols, work plans and/or policies to support the process for collecting this information as well as reviewing requirements to protect information.	April 2022-June 2022
Provide education and training for clinical staff (MA's and RN's) to ensure screening questions are asked and documented at adolescent office visits. Utilize MLADC, who is on staff, to help provide education and act as a resource for Referral to Treatment.	Clinical Manager Clinical Leader Resource Nurses Registered Nurses Medical Assistants Behavioral Health Manager Integrated Behavioral Health Clinicians	Confirm attendance at training session (or 1:1 after session) occurs for all clinical staff. Will be measured by sign in sheet.	June 2022-July 2022
Provide education to provider team to ensure awareness of the measure and how the metric will be tracked.	Clinical Manager Anchor Faculty Physicians Behavioral Health Manager	To be provided at a team meeting	July-August 2022

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	Integrated Behavioral Health Clinicians		
Explore technology solutions to assist with identifying when SBIRT has been done for an adolescent or is outstanding.	Informatics Analysts Clinical Manager Clinical Leader Resource Nurses Anchor Faculty Physician	In concert with Concord Hospital Informatics department, identify ways in which technology could be modified to assist with increasing visibility and awareness when SBIRT screening has not been done in the last 12 months.	July-October 2022
Monitor of reporting on a monthly basis to assess performance, identify staff members who may need additional education or support.	Data Analyst Clinical Manager Clinical Leader Resource Nurses	Clinical Manager will ensure the number of adolescents receiving SBIRT screening is increasing month-over-month, and will work with the clinical leadership team to offer support to team members who are not meeting the goal.	July 2022-December 2022

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Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

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State of New Hampshire

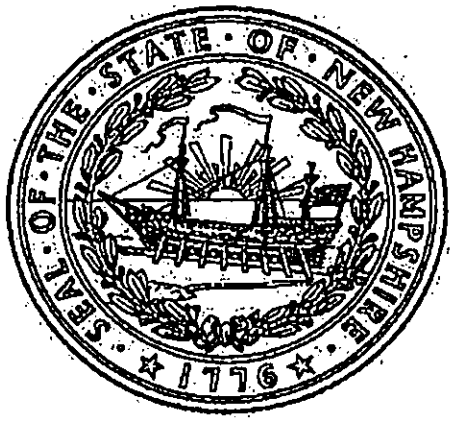
Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that CONCORD HOSPITAL, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on January 29, 1985. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: 74948

Certificate Number : 0005751457



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of April A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE

I, William Chapman, Secretary of Concord Hospital, Inc. do hereby certify:

1) I maintain and have custody of and am familiar with the seal and minute books of the corporation;
2) I am authorized to issue certificates with respect to the contents of such books and to affix such seal to such certificates;
3) The following is a true and complete copy of the resolution adopted by the board of trustees of the corporation at a meeting of that board on March 21, 2005 which meeting was held in accordance with the law of the state of incorporation and the bylaws of the corporation:

   The motion was made, seconded and the Board unanimously voted that the powers and duties of the President shall include the execution of all contracts and other legal documents on behalf of the corporation, unless some other person is specifically so designated by the Board, by law, or pursuant to the administrative policy addressing contract and expenditure approval levels.

4) the foregoing resolution is in full force and effect, unamended, as of the date hereof; and
5) the following persons lawfully occupy the offices indicated below:

   Robert P. Steigmeyer, President
   Scott W. Sloane, Chief Financial Officer

IN WITNESS WHEREOF, I have hereunto set my hand as the Secretary of the Corporation this 13th day of MAY, 2022.

William Chapman
Secretary

DocuSign Envelope ID: 75D16F62-ACF7-4218-B633-98733925BA37

CAPIREG-01 MDUNNING

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/24/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 1780862 HUB International New England 100 Central Street Suite 201 Holliston, MA 01746	CONTACT NAME: Cheryl Walunas PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: cheryl.walunas@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Concord Hospital-Laconia 250 Pleasant Street Concord, NH 03301	INSURER B : The Gray Insurance Company — 36307
	INSURER C :
	INSURER D :
	INSURER E :
	INSURER F :

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		SP4065681	10/1/2021	10/1/2022	☐ PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
B	Excess Worker's Comp			SPX0702401	10/1/2021	10/1/2022	SIR Buy Down	200,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Named Insured includes CONCORD HOSPITAL
Evidence of Excess Workers Compensation - Self-Insured Retention of $650,000

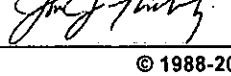
CERTIFICATE HOLDER

NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/16/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. 99 HIGH STREET BOSTON, MA 02110 Attn: Boston.certrequest@Marsh.com CN107277064-CRHC-GIPI-22-23	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED CAPITAL REGION HEALTHCARE CORPORATION & CONCORD HOSPITAL, INC. ATTN: KATHY LAMONTAGNE, ADMINISTRATION 250 PLEASANT STREET CONCORD, NH 03301	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Granite Shield Insurance Exchange **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** NYC-011324775-01 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			GSIE-PRIM-2022-101	01/01/2022	01/01/2023	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 12,000,000
	POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB [ ] OCCUR			GSIE-PRIM-2022-101	01/01/2022	01/01/2023	EACH OCCURRENCE	$ 2,000,000
	X EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$ 2,000,000
	DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			GSIE-PRIM-2022-101	01/01/2022	01/01/2023		SEE ABOVE

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

General Liability and professional Liability share a Combined Limit of 2,000,000/12,000,000. Hospital professional liability Retro active date 06/24/1985. Each Occurrence and aggregate limits are shared amoungst the Granite Shield Exchange Hospitals. Each occurrence and aggregate limits are shared amongst The Granite Shield Exchange Hospitals. General Liability And Professional Liability Share A Combined Limit Of 2,000,000/12,000,000. Hospital Professional Liability Retro Active-Date 05/01/21.

CERTIFICATE HOLDER

State of NH - Dept. of Health and Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh USA Inc.

Concord Hospital Mission Statement

Concord Hospital is a charitable organization which exists to meet the health needs of individuals within the communities it serves.

It is the established policy of Concord Hospital to provide services on the sole basis of the medical necessity of such services as determined by the medical staff without reference to race, color, ethnicity, national origin, sexual orientation, marital status, religion, age, gender, disability, or inability to pay for such services.

Approved by Board of Trustees 10-21-02: Reaffirmed by Board 11-23-03, 11-15-04, 11-21-05, 11-20-06, 11-19-07, 11-17-08, 11-16-09, 10-18-10, 9-19-11, 9-24-12, 9-23-13, 9-22-14, 9-28-15, 9-26-16, 9-25-17, 9-24-18, 9-23-19, 9-28-20, 9-27-21

BAKER NEWMAN NOYES

Concord Hospital, Inc. and Subsidiaries

Audited Consolidated Financial Statements and Supplementary Information and Government Reports in Accordance with Uniform Guidance

Years Ended September 30, 2020 and 2019
With Independent Auditors' Report

Baker Newman & Noyes LLC
MAINE | MASSACHUSETTS | NEW HAMPSHIRE
800.244.7444 | www.bnncpa.com

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

Audited Consolidated Financial Statements
and Supplementary Information and Government
Reports in Accordance with Uniform Guidance

Years Ended September 30, 2020 and 2019

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BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE I MASSACHUSETTS I NEW HAMPSHIRE
800.244.7444 I www.bnncpa.com

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Concord Hospital, Inc.

We have audited the accompanying consolidated financial statements of Concord Hospital, Inc. and Subsidiaries (the System), which comprise the consolidated balance sheets as of September 30, 2020 and 2019, the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

The Board of Trustees
Concord Hospital, Inc.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the System as of September 30, 2020 and 2019, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated December 11, 2020 on our consideration of the System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control over financial reporting and compliance.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 11, 2020, except as to the Supplementary
Schedule of Expenditures of Federal Awards and
Report on Compliance for each Major Federal Program
For which the date is December 23, 2021

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

September 30, 2020 and 2019

ASSETS
(In thousands)

	2020	2019
Current assets:		
Cash and cash equivalents	$ 29,342	$ 6,404
Short-term investments	73,907	23,228
Accounts receivable	66,175	68,614
Due from affiliates	90	492
Supplies	2,871	2,396
Prepaid expenses and other current assets	6,923	6,662
Total current assets	179,308	107,796
Assets whose use is limited or restricted:		
Board designated	296,887	284,668
Funds held by trustee for workers' compensation reserves, self-insurance escrows and construction funds	18,000	38,141
Donor-restricted funds and restricted grants	39,462	39,656
Total assets whose use is limited or restricted	354,349	362,465
Other noncurrent assets:		
Due from affiliates, net of current portion	654	708
Other assets	13,567	18,340
Total other noncurrent assets	14,221	19,048
Property and equipment:		
Land and land improvements	6,332	6,338
Buildings	239,545	194,301
Equipment	255,660	244,834
Construction in progress	12,075	38,734
	513,612	484,207
Less accumulated depreciation	(309,639)	(302,519)
Net property and equipment	203,973	181,688
	$ 751,851	$ 670,997

LIABILITIES AND NET ASSETS
(In thousands)

	2020	2019
Current liabilities:		
Accounts payable and accrued expenses	$ 34,569	$ 34,354
Accrued compensation and related expenses	30,543	28,174
Accrual for estimated third-party payor settlements	48,392	34,569
Current portion of long-term debt	5,186	7,385
Total current liabilities	118,690	104,482
Long-term debt, net of current portion	116,555	120,713
Accrued pension and other long-term liabilities	146,652	74,718
Total liabilities	381,897	299,913
Net assets:		
Without donor restrictions	331,060	333,022
With donor restrictions	38,894	38,062
Total net assets	369,954	371,084
	$ 751,851	$ 670,997

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2020 and 2019
(In thousands)

	2020	2019
Revenue and other support without donor restrictions:		
Patient service revenue	$455,512	$486,272
Other revenue	48,612	21,887
Disproportionate share revenue	18,202	19,215
Net assets released from restrictions for operations	1,983	1,453
Total revenue and other support without donor restrictions	524,309	528,827
Operating expenses:		
Salaries and wages	245,681	250,359
Employee benefits	68,329	61,887
Supplies and other	109,783	106,095
Purchased services	34,943	32,865
Professional fees	7,722	7,681
Depreciation and amortization	24,355	26,150
Medicaid enhancement tax	22,572	22,442
Interest expense	2,595	4,729
Total operating expenses	515,980	512,208
Income from operations	8,329	16,619
Nonoperating income (loss):		
Gifts and bequests without donor restrictions	411	304
Investment income (loss) and other	10,056	(4,906)
Loss on extinguishment of long-term debt	(1,231)	–
Net periodic benefits cost, other than service cost	(2,931)	(2,626)
Total nonoperating income (loss)	6,305	(7,228)
Excess of revenues and nonoperating income (loss) over expenses	$ 14,634	$ 9,391

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS

Years Ended September 30, 2020 and 2019
(In thousands)

	2020	2019
Net assets without donor restrictions:		
Excess of revenues and nonoperating income (loss) over expenses	$ 14,634	$ 9,391
Net unrealized gains on investments	–	4,979
Net transfers from affiliates	(145)	388
Net assets released from restrictions used for purchases of property and equipment	61	188
Pension adjustment	(16,512)	(49,984)
Decrease in net assets without donor restrictions	(1,962)	(35,038)
Net assets with donor restrictions:		
Contributions and pledges with donor restrictions	2,079	1,912
Net investment gain (loss)	945	(103)
Contributions to affiliates and other community organizations	(210)	(186)
Unrealized gains (losses) on trusts administered by others	62	(147)
Net assets released from restrictions for operations	(1,983)	(1,453)
Net assets released from restrictions used for purchases of property and equipment	(61)	(188)
Increase (decrease) in net assets with donor restrictions	832	(165)
Decrease in net assets	(1,130)	(35,203)
Net assets, beginning of year	371,084	406,287
Net assets, end of year	$369,954	$371,084

See accompanying notes.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2020 and 2019
(In thousands)

	2020	2019
Cash flows from operating activities:		
Decrease in net assets	$ (1,130)	$ (35,203)
Adjustments to reconcile decrease in net assets to net cash provided by operating activities:		
Contributions and pledges with donor restrictions	(2,079)	(1,912)
Depreciation and amortization	24,355	26,150
Net realized and unrealized (gains) losses on investments	(7,469)	5,483
Bond premium and issuance cost amortization	(356)	(368)
Equity in earnings of affiliates, net	(4,865)	(7,345)
Loss on disposal of property and equipment	33	35
Loss on extinguishment of long-term debt	1,231	–
Pension adjustment	16,512	49,984
Changes in operating assets and liabilities:		
Accounts receivable	2,439	1,647
Supplies, prepaid expenses and other current assets	(736)	(1,717)
Other assets	5,758	(4,087)
Due from affiliates	456	227
Accounts payable and accrued expenses	6,228	(8,826)
Accrued compensation and related expenses	2,369	1,528
Accrual for estimated third-party payor settlements	13,823	(809)
Accrued pension and other long-term liabilities	55,422	(23,568)
Net cash provided by operating activities	111,991	1,219
Cash flows from investing activities:		
Increase in property and equipment, net	(53,596)	(31,698)
Purchases of investments	(132,901)	(43,333)
Proceeds from sales of investments	95,541	76,304
Equity distributions from affiliates	3,813	6,309
Net cash (used) provided by investing activities	(87,143)	7,582
Cash flows from financing activities:		
Payments on long-term debt	(52,800)	(9,058)
Proceeds from issuance of long-term debt	49,102	–
Bond issuance costs	(256)	–
Contributions and pledges with donor restrictions	2,044	1,970
Net cash used by financing activities	(1,910)	(7,088)
Net increase in cash and cash equivalents	22,938	1,713
Cash and cash equivalents at beginning of year	6,404	4,691
Cash and cash equivalents at end of year	$ 29,342	$ 6,404

Supplemental disclosure:
At September 30, 2019, amounts totaling $6,990 related to the purchase of property and equipment were included in accounts payable and accrued expenses.

See accompanying notes.

1. Description of Organization and Summary of Significant Accounting Policies

Organization

Concord Hospital, Inc., (the Hospital) located in Concord, New Hampshire, is a not-for-profit acute care hospital. The Hospital provides inpatient, outpatient, emergency care and physician services for residents within its geographic region. Admitting physicians are primarily practitioners in the local area. The Hospital is controlled by Capital Region Health Care Corporation (CRHC).

In 1985, the then Concord Hospital underwent a corporate reorganization in which it was renamed and became CRHC. At the same time, the Hospital was formed as a new entity. All assets and liabilities of the former hospital, now CRHC, with the exception of its endowments and restricted funds, were conveyed to the new entity. The endowments were held by CRHC for the benefit of the Hospital, which is the true party in interest. Effective October 1, 1999, CRHC transferred these funds to the Hospital.

In March 2009, the Hospital created The Concord Hospital Trust (the Trust), a separately incorporated, not-for-profit organization to serve as the Hospital's philanthropic arm. In establishing the Trust, the Hospital transferred philanthropic funds with donor restrictions, including board designated funds, endowments, indigent care funds and specific purpose funds, to the newly formed organization together with the stewardship responsibility to direct monies available to support the Hospital's charitable mission and reflect the specific intentions of the donors who made these gifts. Concord Hospital and the Trust constitute the Obligated Group at September 30, 2020 and 2019 to certain debt described in Note 6.

Subsidiaries of the Hospital include:

Capital Region Health Care Development Corporation (CRHCDC) is a not-for-profit real estate corporation that owns and operates medical office buildings and other properties.

Capital Region Health Ventures Corporation (CRHVC) is a not-for-profit corporation that engages in health care delivery partnerships and joint ventures. It operates ambulatory surgery and diagnostic facilities independently and in cooperation with other entities.

NH Cares ACO, LLC (NHC) is a single member limited liability company that engages in providing medical services to Medicare beneficiaries as an accountable care organization. NHC has a perpetual life and is subject to termination in certain events.

The Hospital, its subsidiaries and the Trust are collectively referred to as the System. The consolidated financial statements include the accounts of the Hospital, the Trust, CRHCDC, CRHVC and NHC. All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Concentration of Credit Risk

Financial instruments which subject the Hospital to credit risk consist primarily of cash equivalents, accounts receivable and investments. The risk with respect to cash equivalents is minimized by the Hospital's policy of investing in financial instruments with short-term maturities issued by highly rated financial institutions. The Hospital's accounts receivable are primarily due from third-party payors and amounts are presented net of expected explicit and implicit price concessions, including estimated implicit price concessions from uninsured patients. The Hospital's investment portfolio consists of diversified investments, which are subject to market risk. The Hospital's investment in one fund, the Vanguard Institutional Index Fund, exceeded 10% of total Hospital investments as of September 30, 2020 and 2019.

Cash and Cash Equivalents

Cash and cash equivalents include money market funds with original maturities of three months or less, excluding assets whose use is limited or restricted.

The Hospital maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. The Hospital has not experienced any losses on such accounts.

Supplies

Supplies are carried at the lower of cost, determined on a weighted-average method, or net realizable value.

Assets Whose Use is Limited or Restricted

Assets whose use is limited or restricted include assets held by trustees for workers' compensation reserves, self-insurance escrows, construction funds, designated assets set aside by the Board of Trustees (over which the Board retains control and may, at its discretion, subsequently use for other purposes), and donor-restricted investments.

Investments and Investment Income

Investments are carried at fair value in the accompanying consolidated balance sheets. For 2020, investment income (including realized gains and losses on investments, interest and dividends) and the net change in unrealized gains and losses on investments are included in the excess of revenues and nonoperating income over expenses in the accompanying consolidated statements of operations, unless the income or loss is restricted by donor or law. The change in net unrealized gains and losses on investments in 2019 (prior to the effective date of Accounting Standards Update (ASU) 2016-01 as discussed within the "Recent Accounting Pronouncements" section of Note 1) is reported as a separate component of the change in net assets without donor restrictions, except declines that are determined by management to be other than temporary, which are reported as an impairment charge (included in the excess of revenues and nonoperating income over expenses). No such losses were recorded in 2019.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Beneficial Interest in Perpetual Trusts

The System has an irrevocable right to receive income earned on certain trust assets established for its benefit. Distributions received by the System are without donor restrictions. The System's interest in the fair value of the trust assets is included in assets whose use is limited or restricted and as net assets with donor restrictions. Changes in the fair value of beneficial trust assets are reported as increases or decreases to net assets with donor restrictions.

Investment Policies

The System's investment policies provide guidance for the prudent and skillful management of invested assets with the objective of preserving capital and maximizing returns. The invested assets include endowment, specific purpose and board designated funds.

Endowment funds are identified as perpetual in nature, intended to provide support for current or future operations and other purposes identified by the donor. These funds are managed with disciplined longer-term investment objectives and strategies designed to accommodate relevant, reasonable, or probable events.

Specific purpose funds are temporary in nature, restricted as to time or purpose as identified by the donor or grantor. These funds have various intermediate/long-term time horizons associated with specific identified spending objectives.

Board designated funds have various intermediate/long-term time horizons associated with specific spending objectives as determined by the Board of Trustees.

Management of these assets is designed to increase, with minimum risk, the inflation adjusted principal and income of the endowment funds over the long term. The System targets a diversified asset allocation that places emphasis on achieving its long-term return objectives within prudent risk constraints.

Spending Policy for Appropriation of Assets for Expenditure

In accordance with the *Uniform Prudent Management of Institutional Funds Act* (UPMIFA), the System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: (a) the duration and preservation of the fund; (b) the purpose of the organization and the donor-restricted endowment fund; (c) general economic conditions; (d) the possible effect of inflation and deflation; (e) the expected total return from income and the appreciation of investments; (f) other resources of the organization; and (g) the investment policies of the organization.

Spending policies may be adopted by the System, from time to time, to provide a stream of funding for the support of key programs. The spending policies are structured in a manner to ensure that the purchasing power of the assets is maintained while providing the desired level of annual funding to the programs. The System has a current spending policy on various funds currently equivalent to 5% of twelve-quarter moving average of the funds' total market value.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Accounts Receivable

For accounts receivable resulting from revenue recognized prior to October 1, 2019, an allowance for doubtful accounts was established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, this allowance was estimated based on the aging of accounts receivable, historical collection experience and other factors. Under the provisions of Financial Accounting Standards Board (FASB) ASU No. 2014-09, *Revenue from Contracts with Customers*, which the System adopted effective October 1, 2019 using the full retrospective method, when an unconditional right to payment exists, subject only to the passage of time, the right is treated as a receivable. Patient accounts receivable for which the unconditional right to payment exists are receivables if the right to consideration is unconditional and only the passage of time is required before payment of that consideration is due. As a result of the full retrospective method adoption of ASU No. 2014-09, accounts receivable at September 30, 2020 and 2019 reflect the fact that any estimated uncollectible amounts are generally considered implicit price concessions that are a direct reduction to accounts receivable rather than allowance for doubtful accounts. At September 30, 2020 and 2019, estimated implicit price concessions of $14,072 and $14,635, respectively, had been recorded as reductions to accounts receivable balances to enable the System to record revenues and accounts receivable at the estimated amounts expected to collected.

Property and Equipment

Property and equipment is stated at cost at time of purchase, or at fair value at time of donation for assets contributed, less any reductions in carrying value for impairment and less accumulated depreciation. The System's policy is to capitalize expenditures for major improvements and charge maintenance and repairs currently for expenditures which do not extend the lives of the related assets. Depreciation is computed using the straight-line method in a manner intended to amortize the cost of the related assets over their estimated useful lives. For the years ended September 30, 2020 and 2019, depreciation expense was $24,355 and $26,150, respectively.

The System has also capitalized certain costs associated with property and equipment not yet in service. Construction in progress includes amounts incurred related to major construction projects, other renovations, and other capital equipment purchased but not yet placed in service. During 2020 and 2019, the Hospital capitalized $1,953 and $652, respectively, of interest expense relating to various construction projects.

Gifts of long-lived assets such as land, buildings or equipment are reported as support without donor restrictions, and are excluded from the excess of revenues and nonoperating income over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used, and gifts of cash or other assets that must be used to acquire long-lived assets, are reported as support with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Federal Grant Revenue and Expenditures

Revenues and expenses under federal grant programs are recognized as the grant expenditures are incurred.

Bond Issuance Costs/Original Issue Discount or Premium

Bond issuance costs incurred to obtain financing for construction and renovation projects and the original issue discount or premium are amortized to interest expense using the straight-line method, which approximates the effective interest method, over the life of the respective bonds. The original issue discount or premium and bond issuance costs are presented as a component of bonds payable.

Charity Care

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates (Note 11). Because the System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. The System uses an industry standard approach in calculating the costs associated with providing charity care. Funds received from gifts and grants to subsidize charity services provided for the years ended September 30, 2020 and 2019 were approximately $206 and $88, respectively.

Net Assets With Donor Restrictions

Gifts are reported as restricted support if they are received with donor stipulations that limit the use of donated assets. Donated investments, supplies and equipment are reported at fair value at the date of receipt. Unconditional promises to give cash and other assets are reported at fair value at the date of receipt of the promise. When a donor restriction expires (when a stipulated time restriction ends or purpose restriction is accomplished), net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statement of operations as either net assets released from restrictions for operations (for noncapital related items) or as net assets released from restrictions used for purchases of property and equipment (capital related items). Some net assets with donor restrictions have been restricted by donors to be maintained by the System in perpetuity.

Patient Service Revenue

Prior to the adoption of ASU 2014-09 by the System on October 1, 2019, the System recognized patient service revenue as services were rendered and reported revenue at the estimated net realizable amounts from patients, third-party payors and others for services rendered. On the basis of historical experience, a portion of the System's uninsured patients were unable or unwilling to pay for services provided. Thus, the System recorded a provision for doubtful accounts related to uninsured patients in the period the services were provided. The System adopted the new standard effective October 1, 2019, using the full retrospective method and updated its accounting policies related to revenues, as discussed below. The adoption of the new standard did not have an impact on the recognition of revenues for any periods prior to adoption.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Revenues generally relate to contracts with patients in which the System's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payors and patients is the System's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of accounts receivable. Management performs the hindsight analysis regularly, utilizing rolling twelve-months accounts receivable collection and write-off data. Management believes its regular updates to the estimated implicit price concession amounts provides reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations.

The System receives payment for other Medicaid outpatient services on a reasonable cost basis which are settled with retroactive adjustments upon completion and audit of related cost finding reports. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenues in the year that such amounts become known. For the years ended September 30, 2020 and 2019, patient service revenue in the accompanying consolidated statements of operations increased by approximately $3,400 and $5,600, respectively, due to actual settlements and changes in assumptions underlying estimated future third-party settlements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Revenues from the Medicare and Medicaid programs accounted for approximately 35% and 4% and 34% and 4% of the Hospital's patient service revenue for the years ended September 30, 2020 and 2019, respectively. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation.

Excess of Revenues and Nonoperating Income (Loss) Over Expenses

The System has deemed all activities as ongoing, major or central to the provision of health care services and, accordingly, they are reported as operating revenue and expenses, except for contributions and pledges without donor restrictions, the related philanthropy expenses and investment income which are recorded as nonoperating income.

The consolidated statements of operations also include excess of revenues and nonoperating income (loss) over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues and nonoperating income over expenses, consistent with industry practice, include the permanent transfers of assets to and from affiliates for other than goods and services, pension liability adjustments and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets). Prior to the adoption of ASU 2016-01 on October 1, 2019, unrealized gains and losses on equity securities other than trading securities or losses considered other than temporary were excluded from the performance indicator. Effective October 1, 2019, unrealized gains and losses on equity securities are recorded within the performance indicator in order to conform to ASU 2016-01.

Estimated Workers' Compensation and Health Care Claims

The provision for estimated workers' compensation and health care claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Functional Expense Allocation

The costs of providing program services and other activities have been summarized on a functional basis in Note 10. Accordingly, costs have been allocated among program services and supporting services benefitted.

Income Taxes

The Hospital, CRHCDC, CRHVC, and the Trust are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code, and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. NHC is organized as a single member limited liability company and has elected to be treated as a disregarded entity for federal and state income tax reporting purposes. Accordingly, all income or losses and applicable tax credits are reported on the member's income tax returns, with the exception of taxes due to the State of New Hampshire. Management evaluated the System's tax positions and concluded the System has maintained its tax-exempt status, does not have any significant unrelated business income and had taken no uncertain tax positions that require adjustment to or disclosure in the accompanying consolidated financial statements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

Advertising Costs

The System expenses advertising costs as incurred, and such costs totaled approximately $181 and $251 for the years ended September 30, 2020 and 2019, respectively.

Recent Accounting Pronouncements

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* The ASU supersedes the revenue recognition requirements in Topic 605 (Revenue Recognition) and most industry-specific guidance throughout the Industry Topics of Codification. The core principal of ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The System adopted the new standard effective October 1, 2019, using the full retrospective method. The adoption of the new standard did not have an impact on the recognition of revenues for any periods prior to adoption. The most significant impact of adopting the new standard is the presentation of the consolidated statements of operations, where "patient service revenues" is presented net of estimated implicit price concession revenue deductions. The related presentation of "allowances for doubtful accounts" has also been eliminated from the consolidated balance sheets as a result of the adoption of the new standard.

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments – Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* (ASU 2016-01). ASU 2016-01 requires equity securities to be measured at fair value with changes in fair value recognized through the excess of revenues and nonoperating income (loss) over expenses unless restricted by law or donors. ASU 2016-01 was effective for the System on October 1, 2019 and has been applied on a prospective basis. As a result of adopting ASU 2016-01, unrealized gains and losses on equity securities have been included in investment income (loss) and other in the 2020 consolidated statement of operations. ASU 2016-01 did not impact the accounting for investments in debt securities. As such, unrealized gains and losses on debt securities, if applicable, continue to be excluded from the excess of revenues and nonoperating income (loss) over expenses, and instead are reflected within the change in net assets.

In June 2018, the FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made* (ASU 2018-08). Due to diversity in practice, ASU 2018-08 clarifies the definition of an exchange transaction as well as the criteria for evaluating whether contributions are unconditional or conditional. ASU 2018-08 was effective for the System on October 1, 2019 and has been applied retrospectively to all periods presented. The adoption of ASU 2018-08 did not have a material impact on these consolidated financial statements.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)* (ASU 2016-02). Under ASU 2016-02, at the commencement of a long-term lease, lessees will recognize a liability equivalent to the discounted payments due under the lease agreement, as well as an offsetting right-of-use asset. ASU 2016-02 is effective for the System on October 1, 2022. Lessees (for capital and operating leases) must apply a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements. The modified retrospective approach would not require any transition accounting for leases that expired before the earliest comparative period presented. Lessees may not apply a full retrospective transition approach. The System is currently evaluating the impact of the pending adoption of ASU 2016-02 on the System's consolidated financial statements.

In August 2018, the FASB issued ASU 2018-13, *Fair Value Measurement (Topic 820): Disclosure Framework – Changes to the Disclosure Requirements for Fair Value Measurement* (ASU 2018-13). The amendments in this ASU modify the disclosure requirements for fair value measurements for Level 3 assets and liabilities, and eliminate the requirement to disclose transfers between Levels 1 and 2 of the fair value hierarchy, among other modifications. ASU 2018-13 is effective for the System on October 1, 2020, with early adoption permitted. The System is currently evaluating the impact that ASU 2018-13 will have on its consolidated financial statements.

In September 2020, the FASB issued ASU No. 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets.* ASU 2020-07 enhances the presentation of disclosure requirements for contributed nonfinancial assets. ASU 2020-07 requires entities to present contributed nonfinancial assets as a separate line item in the statement of operations and disclose the amount of contributed nonfinancial assets recognized within the statement of operations by category that depicts the type of contributed nonfinancial assets, as well as a description of any donor-imposed restrictions associated with the contributed nonfinancial assets and the valuation techniques used to arrive at a fair value measure at initial recognition. ASU 2020-07 is effective for the System for transactions in which they serve as the resource recipient beginning October 1, 2021, with early adoption permitted. The System is currently evaluating the impact of the pending adoption of ASU 2020-07 on its financial statements.

Risks and Uncertainties

On March 11, 2020, the World Health Organization declared the outbreak of coronavirus (COVID-19) a pandemic. Patient volumes and the related revenues for most services were significantly impacted in the last two weeks of March 2020 and continued to be impacted in the third and fourth quarters of fiscal 2020 as various policies were implemented by federal, state and local governments in response to the COVID-19 pandemic that have caused many people to remain at home and forced the closure of or limitations on certain businesses, as well as suspended elective procedures by health care facilities.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

While some of these restrictions have been eased across the U.S. and the State of New Hampshire has lifted limitations on nonemergent procedures, some restrictions remain in place. While consolidated patient volumes and revenues experienced gradual improvement beginning in the latter part of April and continuing through the end of the fourth fiscal quarter, uncertainty still exists as the future is unpredictable. The System's pandemic response plan has multiple facets and continues to evolve as the pandemic unfolds. The System has taken precautionary steps to enhance its operational and financial flexibility, and react to the risks the COVID-19 pandemic presents in its operations, including the following:

- Implemented certain cost reduction initiatives;
- Increased the availability on its revolving line of credit from $10,000 to $40,000;
- Elected to defer payments on employer payroll tax incurred through December 31, 2020 as provided for under the Coronavirus Aid, Relief, and Economic Security ("CARES") Act;
- Since the declaration of the pandemic, the System received $57,885 of accelerated Medicare payments (Note 5) and $29,468 in general and targeted Provider Relief Fund distributions, both as provided for under the CARES Act.

The System believes the extent of the COVID-19 pandemic's adverse impact on operating results and financial condition has been and will continue to be driven by many factors, most of which are beyond control and ability to forecast. Such factors include, but are not limited to, the scope and duration of stay-at-home practices and business closures and restrictions, government-imposed or recommended suspensions of elective procedures, continued declines in patient volumes for an indeterminable length of time, increases in the number of uninsured and underinsured patients as a result of higher sustained rates of unemployment, incremental expenses required for supplies and personal protective equipment, and changes in professional and general liability exposure. Because of these and other uncertainties, the System cannot estimate the length or severity of the impact of the pandemic on its operations. Decreases in cash flows and results of operations may have an impact on the inputs and assumptions used in significant accounting estimates, including estimated implicit price concessions related to uninsured patient accounts, and professional and general liability reserves.

During the third quarter of fiscal 2020, the System was awarded $9,539 from the $50 billion general distribution fund and $19,929 of targeted distributions from the CARES Act Provider Relief Fund. These distributions from the Provider Relief Fund are not subject to repayment, provided the System is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants, and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the Provider Relief Fund and the impact of the pandemic on operating results through September 30, 2020, the System recognized $29,468 related to these general distribution funds, and these payments are recorded within other revenue in the consolidated statements of operations for the year ended September 30, 2020.

1. **Description of Organization and Summary of Significant Accounting Policies (Continued)**

The CARES Act also provides for a deferral of payments of the employer portion of payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021 and the remaining half until December 2022. At September 30, 2020, the System had deferred $6,051 of payroll taxes recorded within accrued pension and other long-term liabilities in the accompanying consolidated balance sheet.

The System will continue to monitor compliance with the terms and conditions of the Provider Relief Fund and other potential assistance programs and available grants, and the impact of the pandemic on revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, the System's ability to retain some or all of the distributions received may be impacted.

Subsequent Events

Management of the System evaluated events occurring between the end of the System's fiscal year and December 11, 2020, the date the consolidated financial statements were available to be issued.

On October 19, 2020, the Hospital entered into a proposed asset purchase agreement (the Agreement) with LRGHealthcare (the Seller) to acquire certain assets of Lakes Region General Hospital in Laconia, New Hampshire, and Franklin Regional Hospital in Franklin, New Hampshire. Upon execution of the Agreement, the Seller filed a voluntary case under Chapter 11 of the United States bankruptcy code. As a result, the Agreement is subject to bankruptcy proceedings, including a formal bid process and auction as well as subsequent regulatory approvals should the Hospital's bid be accepted. The outcome of these events is unknown as of the date of these consolidated financial statements, and therefore no amounts have been reflected within these consolidated financial statements related to the above.

2. **Transactions With Affiliates**

The System provides funds to CRHC and its affiliates which are used for a variety of purposes. The System records the transfer of funds to CRHC and the other affiliates as either receivables or directly against net assets, depending on the intended use and repayment requirements of the funds. Generally, funds transferred for start-up costs of new ventures or capital related expenditures are recorded as charges against net assets. For the years ended September 30, 2020 and 2019, transfers made to CRHC were $(457) and $(214), respectively, and transfers received from Capital Region Health Services Corporation (CRHSC) were $312 and $602, respectively.

A brief description of affiliated entities is as follows:

- CRHSC is a for-profit provider of health care services, including an eye surgery center and assisted living facility.
- Concord Regional Visiting Nurse Association, Inc. and Subsidiary (CRVNA) provides home health care services.
- Riverbend, Inc. provides behavioral health services.

(In thousands)

2. Transactions With Affiliates (Continued)

Amounts due the System, primarily from joint ventures, totaled $744 and $1,200 at September 30, 2020 and 2019, respectively. Amounts have been classified as current or long-term depending on the intentions of the parties involved. Beginning in 1999, the Hospital began charging interest on a portion of the receivables ($654 and $708 at September 30, 2020 and 2019, respectively) with principal and interest (6.75% at September 30, 2020) payments due monthly. Interest income amounted to $46 and $50 for the years ended September 30, 2020 and 2019, respectively.

Contributions to affiliates and other community organizations from net assets with donor restrictions were $210 and $186 in 2020 and 2019, respectively.

3. Investments and Assets Whose Use is Limited or Restricted

Short-term investments totaling $73,907 and $23,228 at September 30, 2020 and 2019, respectively, are comprised primarily of cash and cash equivalents. Assets whose use is limited or restricted are carried at fair value and consist of the following at September 30:

	2020	2019
Board designated funds:		
Cash and cash equivalents	$ 961	$ 7,762
Fixed income securities	25,457	23,592
Marketable equity and other securities	258,108	242,088
Inflation-protected securities	12,361	11,226
	296,887	284,668
Held by trustee for workers' compensation reserves:		
Fixed income securities	2,974	3,140
Self-insurance escrows and construction funds:		
Cash and cash equivalents	1,242	10,568
Fixed income securities	3,176	14,816
Marketable equity securities	10,608	9,617
	15,026	35,001
Donor-restricted funds and restricted grants:		
Cash and cash equivalents	4,027	5,930
Fixed income securities	1,850	1,771
Marketable equity securities	21,299	19,865
Inflation-protected securities	1,020	921
Trust funds administered by others	10,965	10,903
Other	301	266
	39,462	39,656
	$354,349	$362,465

(In thousands)

3. **Investments and Assets Whose Use is Limited or Restricted (Continued)**

Included in marketable equity and other securities above are $188,376 and $175,251 at September 30, 2020 and 2019, respectively, in so called alternative investments and collective trust funds. See also Note 14.

Investment income, net realized gains and losses and net unrealized gains and losses on assets whose use is limited or restricted, cash and cash equivalents, and other investments are as follows at September 30:

	2020	2019
Net assets without donor restrictions:		
Interest and dividends	$ 4,894	$ 5,606
Investment income from trust funds administered by others	539	530
Net realized gains (losses) on sales of investments	9,312	(9,863)
Net unrealized (losses) gains on investments	(2,448)	4,979
	12,297	1,252
Net assets with donor restrictions:		
Interest and dividends	402	349
Net realized gains (losses) on sales of investments	768	(779)
Net unrealized (losses) gains on investments	(163)	180
	1,007	(250)
	$13,304	$ 1,002

In compliance with the System's spending policy, portions of investment income and related fees are recognized in other operating revenue on the accompanying consolidated statements of operations. Investment income reflected in other operating revenue was $2,024 and $1,710 in 2020 and 2019, respectively.

Investment management fees expensed and reflected in nonoperating income were $849 and $863 for the years ended September 30, 2020 and 2019, respectively.

In accordance with ASU 2016-01, which the System adopted prospectively on October 1, 2019, no impairment analysis is required as of September 30, 2020 for equity securities. There were no unrealized losses in securities other than equity securities at September 30, 2020. The following summarizes the Hospital's gross unrealized losses and fair values, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at September 30, 2019:

	Less Than 12 Months		12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Marketable equity securities	$ 1,173	$ (432)	$13,650	$ (1,029)	$14,823	$ (1,461)
Fund-of-funds	10,322	(747)	–	–	10,322	(747)
Collective trust funds	13,226	(490)	30,814	(2,497)	44,040	(2,987)
	$24,721	$ (1,669)	$44,464	$ (3,526)	$69,185	$ (5,195)

(In thousands)

3. Investments and Assets Whose Use is Limited or Restricted (Continued)

In evaluating whether investments have suffered an other-than-temporary decline, based on input from outside investment advisors, management evaluated the amount of the decline compared to cost, the length of time and extent to which fair value has been less than cost, the underlying creditworthiness of the issuer, the fair values exhibited during the year, estimated future fair values and the System's intent and ability to hold the security until a recovery in fair value or maturity. Based on evaluations of the underlying issuers' financial condition, current trends and economic conditions, management believes there are no securities that have suffered an other-than-temporary decline in value at September 30, 2019.

4. Defined Benefit Pension Plan

The System has a noncontributory defined benefit pension plan (the Plan), covering all eligible employees of the System and subsidiaries. The Plan provides benefits based on an employee's years of service, age and the employee's compensation over those years. The System's funding policy is to contribute annually the amount needed to meet or exceed actuarially determined minimum funding requirements of the *Employee Retirement Income Security Act of 1974* (ERISA).

The System accounts for its defined benefit pension plan under ASC 715, *Compensation Retirement Benefits*. This Statement requires entities to recognize an asset or liability for the overfunded or underfunded status of their benefit plans in their financial statements.

The following table summarizes the Plan's funded status at September 30, 2020 and 2019:

	2020	2019
Funded status:		
Fair value of plan assets	$ 258,752	$ 251,574
Projected benefit obligation	(327,793)	(304,836)
	$ (69,041)	$ (53,262)
Activities for the year consist of:		
Benefit payments and administrative expenses paid	$ 21,516	$ 26,475
Net periodic benefit cost	15,267	12,958

(In thousands)

4. Defined Benefit Pension Plan (Continued)

The table below presents details about the System's defined benefit pension plan, including its funded status, components of net periodic benefit cost, and certain assumptions used in determining the funded status and cost:

	2020	2019
Change in benefit obligation:		
Projected benefit obligation at beginning of year	$304,836	$267,072
Service cost	12,336	10,332
Interest cost	11,102	12,096
Actuarial loss	19,835	40,111
Benefit payments and administrative expenses paid	(21,516)	(26,475)
Other adjustments to benefit cost	1,200	1,700
Projected benefit obligation at end of year	$327,793	$304,836
Change in plan assets:		
Fair value of plan assets at beginning of year	$251,574	$235,752
Actual return on plan assets	12,694	1,297
Employer contributions	16,000	41,000
Benefit payments and administrative expenses	(21,516)	(26,475)
Fair value of plan assets at end of year	$258,752	$251,574
Funded status and amount recognized in noncurrent liabilities at September 30	$(69,041)	$(53,262)

Amounts recognized as a change in net assets without donor restrictions during the years ended September 30, 2020 and 2019 consist of:

	2020	2019
Net actuarial loss	$ 27,689	$56,890
Net amortized loss	(11,420)	(7,153)
Prior service credit amortization	243	247
Total amount recognized	$ 16,512	$49,984

(In thousands)

4. Defined Benefit Pension Plan (Continued)

Pension Plan Assets

The fair values of the System's pension plan assets as of September 30, 2020 and 2019, by asset category are as follows (see Note 14 for level definitions). In accordance with ASU 2015-07, certain investments that are measured using the net value per share practical expedient have not been classified in the fair value hierarchy.

	2020 Level 1	2019 Level 1
Short-term investments:		
Money market funds	$ 1,189	$ 5,111
Equity securities:		
Common stocks	7,862	9,356
Mutual funds – international	–	9,835
Mutual funds – domestic	72,339	64,805
Mutual funds – inflation hedge	7,685	8,919
Fixed income securities:		
Mutual funds – REIT	525	986
Mutual funds – fixed income	19,628	22,944
	109,228	121,956
Funds measured at net asset value:		
Equity securities:		
Funds-of-funds	87,887	77,700
Collective trust funds:		
Equities	51,545	42,325
Fixed income	10,092	9,593
	149,524	129,618
Total investments at fair value	$258,752	$251,574

The target allocation for the System's pension plan assets as of September 30, 2020 and 2019, by asset category are as follows:

	2020		2019	
	Target Allocation	Percentage of Plan Assets	Target Allocation	Percentage of Plan Assets
Short-term investments	0-20%	0%	0-20%	2%
Equity securities	40-80%	68	40-80%	68
Fixed income securities	5-80%	12	5-80%	13
Other	0-30%	20	0-30%	17

(In thousands)

4. **Defined Benefit Pension Plan (Continued)**

The funds-of-funds are invested with thirteen investment managers and have various restrictions on redemptions. One manager holding amounts totaling approximately $15 million at September 30, 2020 allows for semi-monthly redemptions, with 5 days' notice. One manager holding approximately $7 million at September 30, 2020 allows for monthly redemptions, with 15 days' notice. Six managers holding amounts totaling approximately $38 million at September 30, 2020 allow for quarterly redemptions, with notices ranging from 45 to 65 days. Three of the managers holding amounts of approximately $15 million at September 30, 2020 allow for annual redemptions, with notice ranging from 60 to 90 days. Two of the managers holding amounts of approximately $13 million at September 30, 2020 allows for redemptions on a semi-annual basis, with a notice of 60 days. The collective trust funds allow for daily or monthly redemptions, with notices ranging from 6 to 10 days. Certain funds also may include a fee estimated to be equal to the cost the fund incurs in converting investments to cash (ranging from 0.5% to 1.5%), limit the percent of the investment that can be redeemed each redemption period, or are subject to certain lock periods.

The System considers various factors in estimating the expected long-term rate of return on plan assets. Among the factors considered include the historical long-term returns on plan assets, the current and expected allocation of plan assets, input from the System's actuaries and investment consultants, and long-term inflation assumptions. The System's expected allocation of plan assets is based on a diversified portfolio consisting of domestic and international equity securities, fixed income securities, and real estate.

The System's investment policy for its pension plan is to balance risk and returns using a diversified portfolio consisting primarily of high quality equity and fixed income securities. To accomplish this goal, plan assets are actively managed by outside investment managers with the objective of optimizing long-term return while maintaining a high standard of portfolio quality and proper diversification. The System monitors the maturities of fixed income securities so that there is sufficient liquidity to meet current benefit payment obligations. The System's Investment Committee provides oversight of the plan investments and the performance of the investment managers.

Amounts included in expense during fiscal 2020 and 2019 consist of:

	2020	2019
Components of net periodic benefit cost:		
Service cost	$ 12,336	$ 10,332
Interest cost	11,102	12,096
Expected return on plan assets	(20,548)	(18,076)
Amortization of prior service credit and loss	11,177	6,906
Other adjustments to benefits cost	1,200	1,700
Net periodic benefit cost	$ 15,267	$ 12,958

(In thousands)

4. **Defined Benefit Pension Plan (Continued)**

The accumulated benefit obligations for the plan at September 30, 2020 and 2019 were $310,208 and $288,126, respectively.

	2020	2019
Weighted average assumptions to determine benefit obligation:		
Discount rate	3.11%	3.59%
Rate of compensation increase	2.50% for the next two years; 3.00% thereafter	2.50% for the next three years; 3.00% thereafter
Weighted average assumptions to determine net periodic benefit cost:		
Discount rate	3.59%	4.63%
Expected return on plan assets	7.75	7.75
Cash balance credit rate	5.00	5.00
Rate of compensation increase	2.50/3.00	3.00

In selecting the long-term rate of return on plan assets, the System considered the average rate of earnings expected on the funds invested or to be invested to provide for the benefits of the plan. This included considering the plan's asset allocation and the expected returns likely to be earned over the life of the plan, as well as the historical returns on the types of assets held and the current economic environment.

The loss and prior service credit amount expected to be recognized in net periodic benefit cost in 2021 are as follows:

Actuarial loss	$12,623
Prior service credit	(243)
	$12,380

The System funds the pension plan and no contributions are made by employees. The System funds the plan annually by making a contribution of at least the minimum amount required by applicable regulations and as recommended by the System's actuary. However, the System may also fund the plan in excess of the minimum required amount.

Cash contributions in subsequent years will depend on a number of factors including performance of plan assets. However, the System expects to fund $16,000 in cash contributions to the plan for the 2021 plan year.

(In thousands)

4. Defined Benefit Pension Plan (Continued)

Benefit payments, which reflect expected future service, as appropriate, are expected to be paid as follows:

Year Ended September 30	Pension Benefits
2021	$ 18,023
2022	17,861
2023	18,581
2024	19,090
2025	19,140
2026 – 2030	109,179

5. Estimated Third-Party Payor Settlements

The System has agreements with third-party payors that provide for payments to the System at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare

Inpatient and outpatient services rendered to Medicare program beneficiaries are primarily paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical diagnosis and other factors. In addition to this, the System is also reimbursed for medical education and other items which require cost settlement and retrospective review by the fiscal intermediary. Accordingly, the System files an annual cost report with the Medicare program after the completion of each fiscal year to report activity applicable to the Medicare program and to determine any final settlements.

The physician practices are reimbursed on a fee schedule basis.

Medicaid Enhancement Tax and Disproportionate Share Payment

Under the State of New Hampshire's (the State) tax code, the State imposes a Medicaid Enhancement Tax (MET) equal to 5.40% of net patient service revenues in State fiscal years 2020 and 2019. The amount of tax incurred by the System for 2020 and 2019 was $22,572 and $22,442, respectively.

In the fall of 2010, in order to remain in compliance with stated federal regulations, the State of New Hampshire adopted a new approach related to Medicaid disproportionate share funding (DSH) retroactive to July 1, 2010. Unlike the former funding method, the State's approach led to a payment that was not directly based on, and did not equate to, the level of tax imposed. As a result, the legislation created some level of losses at certain New Hampshire hospitals, while other hospitals realized gains. DSH payments from the State are recorded within revenue without donor restrictions and other support and amounted to $18,202 in 2020 and $19,215 in 2019, net of reserves referenced below.

5. **Estimated Third-Party Payor Settlements (Continued)**

The Centers for Medicare and Medicaid Services (CMS) has completed audits of the State's program and the disproportionate share payments made by the State from 2011 to 2016, the first years that those payments reflected the amount of uncompensated care provided by New Hampshire hospitals. It is possible that subsequent years will also be audited by CMS. The System has recorded reserves to address its potential exposure based on the audit results to date or any future redistributions.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are paid at prospectively determined rates per discharge. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under fee schedules and cost reimbursement methodologies subject to various limitations or discounts. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid program.

The physician practices are reimbursed on a fee schedule basis.

Other

The System has also entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the System under these agreements includes prospectively determined rates per discharge, discounts from established charges, fee schedules, and prospectively determined rates.

The accrual for estimated third-party payor settlements reflected on the accompanying consolidated balance sheets represents the estimated net amounts to be paid under reimbursement contracts with the Centers for Medicare and Medicaid Services (Medicare), the New Hampshire Department of Welfare (Medicaid) and any commercial payors with settlement provision. Settlements for the Hospital have been finalized through 2016 for Medicare and 2015 for Medicaid.

During fiscal year 2020, the System requested accelerated Medicare payments as provided for in the CARES Act, which allows for eligible health care facilities to request up to six months of advance Medicare payments for acute care hospitals or up to three months of advance Medicare payments for other health care providers. One year from the date of receipt of the advance payments (beginning April 2021) 25% of the advances will be recouped in the first eleven months. An additional 25% of the advances will be recouped in the next six months, with the entire amount repayable in 29 months. Any outstanding balance after 29 months is repayable at a 4% interest rate. During the third quarter of fiscal 2020, the System received $57,885 from these accelerated Medicare payment requests, of which the current portion due within a year, totaling $7,893, is recorded under the caption "accrual for estimated third-party payors" and the long-term portion, totaling $49,992, in the caption "accrued pension and other long-term liabilities" in the accompanying consolidated balance sheet for the year ended September 30, 2020.

(In thousands)

6. Long-Term Debt and Revolving Line of Credit

Revolving Line of Credit

In November 2019, the Hospital entered into a $10,000 revolving line of credit agreement with a bank. In June 2020, the Hospital increased the availability on the line of credit to $40,000. Any amounts outstanding under the agreement bear interest at the per annum London Interbank Offered Rate (LIBOR) plus 1.85% (2.24% at September 30, 2020). In the event LIBOR is discontinued while the agreement remains in place, a replacement rate will be assigned, as determined by the bank. The agreement is set to expire on May 30, 2021. The line of credit is secured by substantially all business assets. No amounts were outstanding under this revolving line of credit at September 30, 2020.

Long-term debt consists of the following at September 30, 2020 and 2019:

	2020	2019
2020A note payable to a bank, due October 1, 2026, interest at 1.93% per annum, payable in monthly and annual principal payments ranging from $2,427 to $2,580 beginning October 2022	$ 12,520	$ –
2020B note payable to a bank, due October 1, 2035 (lender has the option to extend the maturity date through October 1, 2043), interest at 2.26% per annum, payable in monthly and annual principal payments ranging from $991 to $2,942 beginning October 2023. Final balloon payment of $10,157 due October 1, 2035, if the maturity date is not extended by the lender	36,582	–
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds, Concord Hospital Issue, Series 2017; interest of 5.0% per year and principal payable in annual installments. Installments ranging from $2,010 to $5,965 beginning October 2032, including unamortized original issue premium of $6,901 in 2020 and $7,215 in 2019	61,111	61,425
3.38% to 5.0% NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013A; due in annual installments, including principal and interest ranging from $1,543 to $3,555 through 2043, including unamortized original issue premium of $242 in 2020 and $2,824 in 2019. Series 2013A revenue bonds totaling $33,785 were refunded in 2020 through issuance of the 2020B note payable described below	2,867	40,469
1.71% fixed rate NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013B; due in annual installments, including principal and interest ranging from $1,860 to $2,038 through 2024	7,601	9,341
4.25% to 5.5% NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2011; due in annual installments, including principal and interest ranging from $2,737 to $5,192 through 2026, including unamortized original issue premium of $19 in 2020 and $136 in 2019. Series 2011 revenue bonds totaling $11,780 were refunded in 2020 through issuance of the 2020A note payable described below	2,044	18,201
	122,725	129,436
Less unamortized bond issuance costs	(984)	(1,338)
Less current portion	(5,186)	(7,385)
	$116,555	$120,713

6. **Long-Term Debt and Notes Payable (Continued)**

In March 2020, the Hospital entered into a $12,520 note payable agreement (2020A note) with a lender to advance refund $11,780 of the Series 2011 NHHEFA Hospital Revenue Bonds. As a result of the advance refunding, the unamortized bond issuance costs and original issue discount related to the bonds refunded were included in loss on extinguishment of debt and totaled $520 for the year ended September 30, 2020. As of September 30, 2020, $11,780 of the Series 2011 advance refunded bonds, which are considered extinguished for purposes of these consolidated financial statements, remain outstanding. In conjunction with the issuance of the 2020A note, in order to further reduce debt service obligations, the Hospital, NHHEFA and the lender entered into a forward purchase agreement. Under the forward purchase agreement, the Hospital has the option to request NHHEFA to issue tax-exempt revenue bonds on or after July 3, 2021 to refinance the 2020A note.

In March 2020, the Hospital entered into a $36,582 note payable agreement (2020B note) with a lender to advance refund the Series 2013A NHHEFA Hospital Revenue Bonds. As a result of the bond refinancing, the unamortized bond issuance costs and original issue premium related to the Series 2013A NHHEFA Hospital Revenue Bonds were included in loss on extinguishment of debt and totaled $711 for the year ended September 30, 2020. As of September 30, 2020, $33,785 of the Series 2013A advance refunded bonds, which are considered extinguished for purposes of these consolidated financial statements, remain outstanding. In conjunction with the issuance of the 2020B note, in order to further reduce debt service obligations, the Hospital, NHHEFA and the lender entered into a forward purchase agreement. Under the forward purchase agreement, the Hospital has the option to request NHHEFA to issue tax-exempt revenue bonds on or after July 3, 2022 to refinance the 2020B note.

In December 2017, $62,004 (including an original issue premium of $7,794) of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2017, were issued to pay for the construction of a new medical office building. In addition, the Series 2017 Bonds reimbursed the Hospital for capital expenditures incurred in association with the construction of a parking garage and the construction of a medical office building, as well as routine capital expenditures.

In February 2013, $48,631 (including an original issue premium of $3,631) of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2013A, were issued to assist in the funding of a significant facility improvement project and to advance refund the Series 2001 NHHEFA Hospital Revenue Bonds. The facility improvement project included enhancements to the System's power plant, renovation of certain nursing units, expansion of the parking capacity at the main campus and various other routine capital expenditures and miscellaneous construction, renovation and improvements of the System's facilities.

In March 2011, $49,795 of NHHEFA Revenue Bonds, Concord Hospital Issue, Series 2011, were issued to assist in the funding of a significant facility improvement project and pay off the Series 1996 Revenue Bonds. The project included expansion and renovation of various Hospital departments, infrastructure upgrades, and acquisition of capital equipment.

(In thousands)

6. Long-Term Debt and Notes Payable (Continued)

Substantially all the property and equipment relating to the aforementioned construction and renovation projects, as well as subsequent property and equipment additions thereto, and a mortgage lien on the facility, are pledged as collateral for all outstanding long-term debt and the revolving line of credit. In addition, the gross receipts of the Hospital are also pledged as collateral for all outstanding long-term debt and the revolving line of credit. The most restrictive financial covenants require a 1.10 to 1.0 ratio of aggregate income available for debt service to total annual debt service and a day's cash on hand ratio of 75 days. The Hospital was in compliance with its debt covenants at September 30, 2020 and 2019.

The obligations of the Hospital under the 2020A and B notes, Series 2017, Series 2013A and B and Series 2011 Revenue Bond Indentures are not guaranteed by any of the subsidiaries or affiliated entities.

Interest paid on long-term debt amounted to $4,888 (including capitalized interest of $1,953) and $5,697 (including capitalized interest of $652) for the years ended September 30, 2020 and 2019, respectively.

The aggregate principal payments on long-term debt for the next five fiscal years ending September 30 and thereafter are as follows:

2021	$ 5,186
2022	5,636
2023	6,239
2024	6,298
2025	5,339
Thereafter	86,865
	$ 115,563

7. Commitments and Contingencies

Malpractice Loss Contingencies

Effective February 1, 2011, the System insures its medical malpractice risks through a multiprovider captive insurance company under a claims-made insurance policy. Premiums paid are based upon actuarially determined amounts to adequately fund for expected losses. At September 30, 2020, there were no known malpractice claims outstanding for the System, which, in the opinion of management will be settled for amounts in excess of insurance coverage, nor were there any unasserted claims or incidents which require loss accruals. The System has established reserves for unpaid claim amounts for Hospital and Physician Professional Liability and General Liability reported claims and for unreported claims for incidents that have been incurred but not reported. The amounts of the reserves total $4,081 and $3,834 at September 30, 2020 and 2019, respectively and are reflected in the accompanying consolidated balance sheets within accrued pension and other long-term liabilities. The possibility exists, as a normal risk of doing business, that malpractice claims in excess of insurance coverage may be asserted against the System.

7. **Commitments and Contingencies (Continued)**

The captive retains and funds up to actuarial expected loss amounts, and obtains reinsurance at various attachment points for individual and aggregate claims in excess of funding in accordance with industry practices. At September 30, 2020, the System's interest in the captive represents approximately 80% of the captive. The System accounts for its investments in the captive under the equity method since control of the captive is shared equally between the participating hospitals. The System has recorded its interest in the captive's equity, totaling approximately $5,509 and $7,270 at September 30, 2020 and 2019, respectively, in other noncurrent assets on the accompanying consolidated balance sheets. Changes in the System's interest are included in nonoperating income on the accompanying consolidated statements of operations

In accordance with ASU No. 2010-24, "*Health Care Entities*" (Topic 954): *Presentation of Insurance Claims and Related Insurance Recoveries*, at September 30, 2020 and 2019, the Hospital recorded a liability of approximately $3,000 and $4,100, respectively, related to estimated professional liability losses. At September 30, 2020 and 2019, the Hospital also recorded a receivable of $3,000 and $4,100, respectively, related to estimated recoveries under insurance coverage for recoveries of the potential losses. These amounts are included in accrued pension and other long-term liabilities and other assets, respectively, on the consolidated balance sheets.

Workers' Compensation

The Hospital maintains workers' compensation insurance under a self-insurance plan. The plan offers, among other provisions, certain specific and aggregate stop-loss coverage to protect the Hospital against excessive losses. The Hospital has employed independent actuaries to estimate the ultimate costs, if any, of the settlement of such claims. Accrued workers' compensation losses of $2,388 and $2,797 at September 30, 2020 and 2019, respectively, are recorded within accounts payable and accrued expenses on the accompanying consolidated balance sheets and have been discounted at 3% (both years) and, in management's opinion, provide an adequate reserve for loss contingencies. A trustee held fund has been established as a reserve under the plan. Assets held in trust totaled $2,974 and $3,140 at September 30, 2020 and 2019, respectively, and is included in assets whose use is limited or restricted in the accompanying consolidated balance sheets.

Litigation

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the System's financial position, results of operations or cash flows.

Health Insurance

The System has a self-funded health insurance plan. The plan is administered by an insurance company which assists in determining the current funding requirements of participants under the terms of the plan and the liability for claims and assessments that would be payable at any given point in time. The System recognizes revenue for services provided to employees of the System during the year. The System is insured above a stop-loss amount of $440 on individual claims. Estimated unpaid claims, and those claims incurred but not reported at September 30, 2020 and 2019, have been recorded as a liability of $5,709 and $4,391, respectively, and are reflected in the accompanying consolidated balance sheets within accounts payable and accrued expenses.

(In thousands)

7. Commitments and Contingencies (Continued)

Operating Leases

The System has various operating leases relative to its office and offsite locations. Future annual minimum lease payments under noncancellable lease agreements as of September 30, 2020 are as follows:

Year Ending September 30:	
2021	$ 6,437
2022	6,119
2023	5,990
2024	5,273
2025	3,758
Thereafter	9,651
	$ 37,228

Rent expense was $7,125 and $7,392 for the years ended September 30, 2020 and 2019, respectively.

8. Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at September 30:

	2020	2019
Purpose restriction:		
Health education and program services	$ 14,997	$ 14,734
Capital acquisitions	1,870	1,764
Indigent care	126	133
Pledges receivable with stipulated purpose and/or time restrictions	283	223
	17,276	16,854
Perpetual in nature:		
Health education and program services	18,744	18,319
Capital acquisitions	803	803
Indigent care	1,811	1,811
Annuities to be held in perpetuity	260	275
	21,618	21,208
Total net assets with donor restrictions	$ 38,894	$ 38,062

(In thousands)

9. Patient Service Revenue

An estimated breakdown of patient service revenues for the Hospital by major payor sources is as follows for the years ended September 30:

	2020	2019
Private payor (includes coinsurance and deductibles)	$270,386	$288,321
Medicare	158,386	166,737
Medicaid	18,646	21,602
Self-pay	6,176	6,876
	$453,594	$483,536

10. Functional Expenses

The System provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows for the years ended September 30:

	Health Services	General and Administrative	Fund-raising	Total
2020				
Salaries and wages	$203,587	$41,594	$ 500	$245,681
Employee benefits	56,622	11,568	139	68,329
Supplies and other	96,353	13,346	84	109,783
Purchased services	21,062	13,753	128	34,943
Professional fees	7,722	–	–	7,722
Depreciation and amortization	16,363	7,735	257	24,355
Medicaid enhancement tax	22,572	–	–	22,572
Interest	1,756	812	27	2,595
	$426,037	$88,808	$1,135	$515,980
2019				
Salaries and wages	$208,279	$41,607	$ 473	$250,359
Employee benefits	51,485	10,285	117	61,887
Supplies and other	91,029	14,912	154	106,095
Purchased services	24,362	8,369	134	32,865
Professional fees	7,675	6	–	7,681
Depreciation and amortization	17,459	8,415	276	26,150
Medicaid enhancement tax	22,442	–	–	22,442
Interest	3,173	1,506	50	4,729
	$425,904	$85,100	$1,204	$512,208

(In thousands)

10. Functional Expenses (Continued)

The consolidated financial statements report certain expense categories that are attributable to more than one healthcare service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as depreciation and interest, are allocated to a function based on square footage. Supporting activities that are not directly identifiable with one or more healthcare programs are classified as general and administrative. If it is impossible or impractical to make a direct identification, allocation of the expenses were made according to management's estimates. Employee benefits are allocated in accordance with the ratio of salaries and wages of the functional classes. Specifically identifiable costs are assigned to the function which they are identified to.

11. Charity Care and Community Benefits (Unaudited)

The Hospital maintains records to identify and monitor the level of charity care it provides. The Hospital provides traditional charity care, as well as other forms of community benefits. The estimated cost of all such benefits provided is as follows for the years ended September 30:

	2020	2019
Government sponsored healthcare	$31,319	$29,683
Community health services	1,582	2,190
Health professions education	2,304	2,874
Subsidized health services	44,867	42,431
Research	81	84
Financial contributions	829	552
Community building activities	–	40
Community benefit operations	72	70
Charity care costs (see Note 1)	3,445	4,696
	$84,499	$82,620

The Hospital incurred estimated costs for services to Medicare patients in excess of the payment from this program of $71,877 and $57,580 in 2020 and 2019, respectively.

(In thousands)

12. Concentration of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents of southern New Hampshire and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors as of September 30 is as follows:

	2020	2019
Patients	10%	12%
Medicare	37	32
Anthem Blue Cross	15	14
Cigna	4	3
Medicaid	9	11
Commercial	23	25
Workers' compensation	2	3
	100%	100%

13. Volunteer Services (Unaudited)

Total volunteer service hours received by the Hospital were approximately 16,290 in 2020 and 24,200 in 2019. The volunteers provide various nonspecialized services to the Hospital, none of which has been recognized as revenue or expense in the accompanying consolidated statements of operations.

14. Fair Value Measurements

Fair value of a financial instrument is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the System uses various methods including market, income and cost approaches. Based on these approaches, the System often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The System utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques, the System is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the quality and reliability of the information used to determine fair values. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

(In thousands)

14. Fair Value Measurements (Continued)

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third party pricing services for identical or similar assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models and similar techniques, and not based on market exchange, dealer or broker traded transactions. Level 3 valuations incorporate certain assumptions and projections in determining the fair value assigned to such assets or liabilities.

In determining the appropriate levels, the System performs a detailed analysis of the assets and liabilities. There have been no changes in the methodologies used at September 30, 2020 and 2019. In accordance with ASU 2015-07, certain investments that are measured using the net value per share practical expedient have not been classified in the fair value hierarchy.

The following presents the balances of assets measured at fair value on a recurring basis at September 30:

	Level 1	Level 2	Level 3	Total
2020				
Cash and cash equivalents	$ 80,137	$ –	$ –	$ 80,137
Fixed income securities	30,415	–	–	30,415
Marketable equity and other securities	101,639	–	–	101,639
Inflation-protected securities and other	13,682	–	–	13,682
Trust funds administered by others	–	–	10,965	10,965
	$225,873	$ –	$10,965	236,838
Funds measured at net asset value:				
Marketable equity and other securities				188,376
				$425,214
2019				
Cash and cash equivalents	$ 47,488	$ –	$ –	$ 47,488
Fixed income securities	41,310	–	–	41,310
Marketable equity and other securities	96,319	–	–	96,319
Inflation-protected securities and other	12,413	–	–	12,413
Trust funds administered by others	–	–	10,903	10,903
	$197,530	$ –	$10,903	208,433
Funds measured at net asset value:				
Marketable equity and other securities				175,251
				$383,684

(In thousands)

14. Fair Value Measurements (Continued)

In addition, for the years ended September 30, 2020 and 2019, there are certain investments totaling $3,042 and $2,009, respectively, which are appropriately being carried at cost.

The System's Level 3 investments consist of funds administered by others. The fair value measurement is based on significant unobservable inputs.

Investments, in general, are exposed to various risks, such as interest rate, credit and overall market volatility. As such, it is reasonably possible that changes in the fair value of investments will occur in the near term and that such changes could materially affect the amounts reported in the accompanying consolidated balance sheets and statements of operations.

A reconciliation of the fair value measurements using significant unobservable inputs (Level 3) is as follows for 2020 and 2019:

	Trust Funds Administered by Others
Balance at September 30, 2018	$11,051
Net realized and unrealized losses	(148)
Balance at September 30, 2019	10,903
Net realized and unrealized gains	62
Balance at September 30, 2020	$10,965

The table below sets forth additional disclosures for investment funds (other than mutual funds) valued based on net asset value to further understand the nature and risk of the investments by category:

	Fair Value	Unfunded Commit-ments	Redemption Frequency	Redemption Notice Period
September 30, 2020:				
Funds-of-funds	$17,543	$ –	Semi-monthly	5 days
Funds-of-funds	9,468	–	Monthly	15 days
Funds-of-funds	48,190	–	Quarterly	45 – 65 days**
Funds-of-funds	23,631	–	Annual	60 - 90 days
Funds-of-funds	9,631	–	Semi-annual	60 days*
Funds-of-funds	9,717	20,156	Illiquid	N/A
Collective trust funds	15,326	–	Daily	10 days
Collective trust funds	4,980	–	Weekly	10 days
Collective trust funds	49,890	–	Monthly	6 – 10 days

(In thousands)

14. Fair Value Measurements (Continued)

	Fair Value	Unfunded Commit-ments	Redemption Frequency	Redemption Notice Period
September 30, 2019:				
Funds-of-funds	$15,855	$ –	Semi-monthly	5 days
Funds-of-funds	10,123	–	Monthly	15 days
Funds-of-funds	57,755	–	Quarterly	45 – 65 days
Funds-of-funds	14,807	–	Annual	60 - 90 days
Funds-of-funds	8,912	–	Semi-annual	60 days*
Funds-of-funds	4,979	15,283	Illiquid	N/A
Collective trust funds	14,569	–	Daily	10 days
Collective trust funds	48,251	–	Monthly	6 – 10 days

* Limited to 25% of the investment balance at each redemption.
** One investment has a one-year lock period and redemption of one investment is limited to 12.5% of the investment balance at each redemption.

Investment Strategies

Fixed Income Securities

The primary purpose of fixed income investments is to provide a highly predictable and dependable source of income, preserve capital, and reduce the volatility of the total portfolio and hedge against the risk of deflation or protracted economic contraction.

Marketable Equity and Other Securities

The primary purpose of marketable equity investments is to provide appreciation of principal and growth of income with the recognition that this requires the assumption of greater market volatility and risk of loss. The total marketable equity portion of the portfolio will be broadly diversified according to economic sector, industry, number of holdings and other characteristics including style and capitalization. The System may employ multiple equity investment managers, each of whom may have distinct investment styles. Accordingly, while each manager's portfolio may not be fully diversified, it is expected that the combined equity portfolio will be broadly diversified.

The System invests in other securities that are considered alternative investments that consist of limited partnership interests in investment funds, which, in turn, invest in diversified portfolios predominantly comprised of equity and fixed income securities, as well as options, futures contracts, and some other less liquid investments. Management has approved procedures pursuant to the methods in which the System values these investments at fair value, which ordinarily will be the amount equal to the pro-rata interest in the net assets of the limited partnership, as such value is supplied by, or on behalf of, each investment from time to time, usually monthly and/or quarterly by the investment manager. Collective trust funds are generally valued based on the proportionate share of total fund net assets.

(In thousands)

14. Fair Value Measurements (Continued)

System management is responsible for the fair value measurements of investments reported in the consolidated financial statements. Such amounts are generally determined using audited financial statements of the funds and/or recently settled transactions and is estimated using the net asset value per share of the fund. Because of inherent uncertainty of valuation of certain alternative investments, the estimate of the fund manager or general partner may differ from actual values, and differences could be significant. Management believes that reported fair values of its alternative investments at the balance sheet dates are reasonable.

The Hospital has committed to invest up to $28,683 with various investment managers, and had funded $8,527 of that commitment as of September 30, 2020. As these investments are made, the Hospital reallocates resources from its current investments resulting in an asset allocation shift within the investment pool.

Inflation-Protected Securities

The primary purpose of inflation-protected securities is to provide protection against the negative effects of inflation.

Fair Value of Other Financial Instruments

Other financial instruments consist of accounts and pledges receivable, accounts payable and accrued expenses, estimated third-party payor settlements, and long-term debt and notes payable. The fair value of all financial instruments other than long-term debt and notes payable approximates their relative book values as these financial instruments have short-term maturities or are recorded at amounts that approximate fair value. The fair value of the System's long-term debt and notes payable is estimated using discounted cash flow analyses, based on the System's current incremental borrowing rates for similar types of borrowing arrangements. The carrying value and fair value of the System's long-term debt and notes payable amounted to $122,725 and $135,943, respectively, at September 30, 2020, and $129,436 and $148,672, respectively, at September 30, 2019.

15. Financial Assets and Liquidity Resources

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs, consisted of the following at September 30, 2020:

Cash and cash equivalents	$ 29,342
Short-term investments	73,907
Accounts receivable	66,175
Funds held by trustee for workers' compensation reserves, self-insurance escrows and construction costs	18,000
	$187,424

15. Financial Assets and Liquidity Resources

To manage liquidity, the System maintains sufficient cash and cash equivalent balances to support daily operations throughout the year. Cash and cash equivalents and short-term investments include bank deposits, money market funds, and other similar vehicles that generate a return on cash and provide daily liquidity to the System. In addition, the System has board-designated assets without donor restrictions that can be utilized at the discretion of management to help fund both operational needs and/or capital projects. As of September 30, 2020, the balance of liquid investments in board-designated assets was $287,980.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended September 30, 2020

Federal Grantor/Pass-Through Grantor/Program or Cluster Title	Pass-Through Award Number	Assistance Listing Number	Amounts Provided to Subrecipients	Federal Expenditures
U.S. Department of Health and Human Services:				
Pass-through State of New Hampshire				
Department of Health and Human Services:				
Access and Delivery Hub for Opioid Use Disorder Services	05-95-92-7040-500731	93.788	$668,199	$677,403*
Primary Care Services for Specific Counties	05-95-90-902010-51900000 -102-500731	93.994	–	63,157
Family Planning Services	05-95-45-450010-6146	93.558	–	40,040
New Hampshire Breast and Cervical Cancer Program	NU58DP006298	93.898	–	13,415
Pass through Foundation for Healthy Communities:				
Substance Use Disorder Emergency Department Project	05-95-49-491510-2990	93.959	–	32,012
U.S. Department of Treasury:				
Pass-through State of New Hampshire				
Department of Health and Human Services:				
COVID-19 Coronavirus Relief Fund, Child Care Recovery and Stabilization Program	COVID-19	21.019	–	38,119
Total expenditures of federal awards			$668,199	$864,146

* Major program

See notes to this schedule.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended September 30, 2020

1. Basis of Presentation

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) summarizes the federal grant activity of Concord Hospital, Inc. and Subsidiaries (the System) for the year ended September 30, 2020, and is presented on the accrual basis of accounting. The Schedule includes all applicable federal grants for the System. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. Code of Federal Regulations, Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Since the Schedule presents only a selected portion of the operations of the System, it is not intended to and does not present the financial position, results of operations, changes in net assets or cash flows of the System.

For purposes of the Schedule, federal awards include all grants, contracts and similar agreements entered into directly between the System and agencies and departments of the federal government and all subawards to the System by nonfederal organizations pursuant to federal grants, contracts and similar agreements.

2. Summary of Significant Accounting Policies

Expenditures for direct costs are recognized as incurred using the accrual method of accounting and the cost accounting principles contained in Uniform Guidance, as applicable. Under these cost principles, certain types of expenditures are not allowable or are limited as to reimbursement. The categorization of expenditures by program included in the Schedule is based upon the Assistance Number Listing. The System has elected to use the 10-percent de minimis indirect cost rate as allowed under the Uniform Guidance.

3. Pass-Through Awards

The System receives certain federal awards in the form of pass-through awards. Such amounts received as pass-through awards are specifically identified on the Schedule.

4. Donated Personal Protective Equipment (PPE) (Unaudited)

During the year ended September 30, 2020, the System did not receive donated PPE.

BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
MAINE I MASSACHUSETTS I NEW HAMPSHIRE
800.244.7444 I www.bnncpa.com

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

The Board of Trustees
Concord Hospital, Inc.

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, the financial statements of Concord Hospital, Inc. and Subsidiaries (the System), which comprise the consolidated balance sheets as of September 30, 2020 and 2019, the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated December 11, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The Board of Trustees
Concord Hospital, Inc.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the System's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the consolidated financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 11, 2020

BAKER NEWMAN NOYES

Baker Newman & Noyes LLC
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INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE

The Board of Trustees
Concord Hospital, Inc.

Report on Compliance for Each Major Federal Program

We have audited Concord Hospital, Inc. and Subsidiaries (the System) compliance with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Compliance Supplement* that could have a direct and material effect on each of the System's major federal programs for the year ended September 30, 2020. The System's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of Federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of the System's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 of the U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the System's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the System's compliance.

The Board of Trustees
Concord Hospital, Inc.

Opinion on Each Major Federal Program

In our opinion, the System complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2020.

Report on Internal Control Over Compliance

Management of the System is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the System's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the System's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Baker Newman & Noyes LLC

Manchester, New Hampshire
December 23, 2021

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended September 30, 2020

I. Summary of Auditors' Results

Financial Statements:

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	*Unmodified*	
Internal control over financial reporting:		
• Material weakness(es) identified?	___ yes	X no
• Significant deficiency(ies) identified?	___ yes	X none reported
Noncompliance material to financial statements noted?	___ yes	X no

Federal Awards:

Internal control over major programs:		
• Material weakness(es) identified?	___ yes	X no
• Significant deficiency(ies) identified?	___ yes	X none reported
Type of auditors' report issued on compliance for major federal programs:	*Unmodified*	
Any audit findings disclosed that are required to be reported in accordance with Section 2 CFR 200.516(a)?	___ yes	X no

Identification of Major Programs:

CFDA #	Name of Federal Program or Cluster
93.788	U.S. Department of Health and Human Services: Pass-Through State of New Hampshire Department of Health and Human Services: Access and Delivery Hub for Opioid Use Disorder Services

Dollar threshold used to distinguish between Type A and Type B programs:	$750,000	
Auditee qualified as low-risk auditee?	___ yes	X no

II. Financial Statement Findings

Findings related to the financial statements which are required to be reported in accordance with Government Auditing Standards:

No matters were reported.

III. Federal Award Findings and Questioned Costs

Findings required to be reported in accordance with 2 CFR 200.516(a):

No matters were reported.

CONCORD HOSPITAL, INC. AND SUBSIDIARIES

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended September 30, 2020

There were no reported findings from the prior period.

CONCORD HOSPITAL
BOARD OF TRUSTEES
2022

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Robert Steigmeyer, **President/CEO** (ex-officio)
Jeffrey Towle
Donald Welford

Treasurer (not Member of the Board):
Scott W. Sloane

1/2022

Amanda DeCook

EDUCATION

Master of Science Degree
Health Information Management, New England College, Henniker, NH (May, 2010)
Academic Honors: Graduated Magna Cum Laude

Bachelor of Science Degree
Business Management Program, Franklin Pierce College, Concord, NH (May, 2000)
Marketing Certificate, Franklin Pierce College, Concord, NH (May, 2000)
Academic Honors: Graduated Cum Laude

Associate of Applied Science Degree
Applied Business Management Program, University of New Hampshire, Durham, NH (May, 1992)
GPA 3.68, Graduated with High Honors
Academic Honors: Dean's List every semester, Included High and Highest Honors

Related Skills:

Professional Training:
Advanced Seagate Crystal Reports (Certificate of completion)
Advanced Microsoft Access® (Certificate of completion)
Microsoft Office® & SPC XL Control Charts
Microsystems (The Dartmouth Institute, TDI)
Statistical Measurement and Analysis for Quality Improvement (TDI)
Medicalogic Expression Language (MEL) Programming
Supporting Windows (Microsoft® Certificate of completion)
Yellow Belt Performance Improvement (Certificate of completion, TDI)

Business, Managerial:
Financial & Managerial Accounting
Human Relations
Human Resource Management
Marketing Management
Medical Terminology
Organizational Behavior

WORK EXPERIENCE

1999 – present **Data Manager,** NH Dartmouth Family and Leadership in Preventive Medicine Residencies, Concord Hospital, Concord, NH. Data manager in residency and practice improvement environments for various grants. Work closely with the evaluation teams, responsibilities include serving as a main resource for data capture, retrieval, and database management for project faculty and learner practice improvement efforts. Involvement with many aspects of quality improvement initiatives in the combined Family and Preventive Medicine Residency with a focus on Electronic Care Plans and the integral role they support in the Medical Home improvement efforts.

1999 – present **Application Analyst III,** NH Dartmouth Family and Leadership in Preventive Medicine Residencies, Concord Hospital, Concord, NH. Perform as project manager on the creation, development, and implementation of new Centricity EMR/EHR applications, advanced Crystal Reports writing, encounter form design with the use of MEL programming, and data analysis with the use of SPC XL control charting. Work closely with Family and Preventive Medicine Residents as senior data analyst for completion of Practicum projects. Development and maintenance of various MS Access databases for tracking patient information, research projects, expense tracking, and ITS project tracking. Back up for daily desktop support to physician, faculty, and staff on hardware, software, networking and telecommunications issues. Participation in various Concord Hospital department meetings including multiple Quality Improvement Process Workgroups and Lean training. Co-author of faculty and resident publications.

1998 - 1999 **Technical Support Specialist,** CIGNA, Hooksett, NH. Responsible for daily telephone support in the personal computer and networking fields for Healthsource/CIGNA Plans with a customer base of over 700 end users. Responsible for troubleshooting TCP/IP conflicts, Novell 4.11 Netware Administrator for Windows 95 end user support, troubleshooting and solving telecommunications issues, determination and escalation of first level support calls to second level as necessary. Responsible for software support including all MS Office 97 applications.

GroupWise v4.1 and v5.2, MS IE v4.0, Netscape, WordPerfect, and Norton Antivirus. Provide software installation and hardware troubleshooting and support. Supporting MHS calls from various CIGNA plans. Reporting statistical information with the use of Seagate Crystal Reports to document call volume off a Vantive support database.

1997 - 1998 **Support Analyst,** Healthsource, Hooksett, NH. Responsible for analyzing requested projects, user reported problems, determining the extent and type of system modifications required within the MHC Support Department and provide on-going support to end users. Duties include working with programmers and managers within the IS Department and affiliate plans on a daily basis with concentration in the Enrollment and Finance divisions. Responsible for testing and assessment of test plans for user requested system modifications. Daily tasks such as accessing the Data Warehouse and creating queries, billing rate adjustments, recreating and testing report and tape processes, data fixes, file editing, creating and maintaining the claim adjustment code file.

1994 - 1996 **Project Coordinator,** Healthsource, Hooksett, NH. Responsibilities include implementation of a new help desk database with the MHC Support Department. Working with the Benefits Support Department on code file projects, creating new adjustment and reason codes, printing and distributing database reports and fact sheets. Maintaining project files as requested within the IS Department.

PUBLICATIONS / PROFESSIONAL PRESENTATIONS

Valeras, A.S., Morse, J., Valeras, A.B., Eubank, D., Geffken, D.G., Harker, P.T. & DeCook, A. (2013). Addressing avoidable ED utilization and rehospitalization as symptoms of complexity through a quality improvement methodology. STFM Conference on Practice Improvement, San Diego, CA.

Ballard, J.B., Valeras, A.B., Geffken, D., & DeCook, A. (2013). Team-based patient-centered care to improve cardiovascular disease outcomes at a safety-net PCMH. STFM Conference on Practice Improvement, San Diego, CA.

Council, L., Geffken, D., Valeras, A.B, Orzano, J., Rechisky, A., & Anderson, S. (2012). A medical home: Changing the way patients and teams relate through Patient Centered Care Plans. *Families, Systems & Health, 30,* 190-198.

Poster presentation (co-author): "A Multi-Faceted Educational Intervention to Improve Appropriate Inter-pregnancy Intervals: A Pre-Post Study." Family Medicine Education Consortium: Northeast Region Meeting Danvers, MA, 3/08/2012.

Published article (co-author): "Group counseling improves quality for patients with limited health literacy", Quality in Primary Care, 2010.

Poster presentation (co-author): "Improving Care at the End of Life: Creating Patient Centered Advanced Directive." NH Dartmouth Family and Preventive Medicine Residency, 6/2009.

Poster presentation (co-author): "Care Plans with Patients with Mental Health Diagnoses at the Concord Hospital Family Health Center." NH Dartmouth Family and Preventive Medicine Residency, 6/2009.

Poster presentation (co-author): "Improving Immunization Rates of 2-Year-Olds in a Community Health Center-based Residency Program." NH Dartmouth Family and Preventive Medicine Residency, 6/2008.

References and professional letters of recommendation furnished upon request

TERI L. BREHIO, MD

RESIDENCY

June 25, 2001 – August 2004 NH Dartmouth Family Medicine Residency

WORK EXPERIENCE

May 10, 2020 – Present Concord Family Health Centers – Concord and Hillsboro-Deering and the RICH Program

Medical Director

- Oversee patient care activities including primary care, specialty care, dental clinic, elder care, home care and behavioral health
- Active member of the residency faculty, engaged in resident and medical student education
- Oversee the coordination of various practice activities to improve patient care outcomes and workflows
- Actively involved in the recruitment of high caliber providers and staff
- Participate with the Administrative Director in the management of the budget
- Implement policies/procedures/algorithm that impact medical practice of providers at all practices
- Accountable for annual performance reviews, as assigned

June 1, 2011 – April 2020 NH Dartmouth Family Medicine Residency
Concord, NH

Education Director

- Participate on the Leadership Team for the Residency
- Supervise faculty, including performance reviews
- Perform 6-month reviews for the residents
- Oversee the Curriculum Committee
- Co-lead the Academic Division Meetings

September 2004 – Present NH Dartmouth Family Medicine Residency
Concord, NH

Faculty Attending

- Provide full spectrum outpatient primary care, including obstetrics

- Precept resident outpatient clinics
- Attending physician on the Obstetric service
- Curriculum Coordinator for the Musculoskeletal/Sports Medicine Rotation

  -Review and revise the curriculum goals and objectives annually, after meeting with the Orthopaedic Physicians and incorporating their feedback

  -Make changes to the curriculum, as needed, to improve resident education

  -Liaison between the residency and the Orthopaedic Physicians and athletic directors

  -Facilitate the residents ability to sign-up for sporting events attendance and monitor the requirements for this

- Inpatient Critical Care Curriculum Coordinator

  -Review and revise the curriculum goals and objectives annually, after meeting with the Critical Care Physicians and incorporating their feedback.

  -Make changes to the curriculum, as needed, to improve resident education

  -Liaison between the residency and the Critical Care Physicians

- Member of the Concord Hospital Medical Group Provider Relations Committee

  -Meet monthly to discuss issues related to Provider satisfaction and retention.

September 2005 – May 2008 New England College
Henniker, NH

Medical Director

- Review and approve Policies and Procedures for the Medical Center
- Supervise the Senior Resident that is running the physician clinic weekly

PRESENTATIONS

October 2010 Northeast Regional Electronic Medical Record Conference – "AutumnLogic"
"Finding Time: Incorporating the EMR Effectively into the Visit"

May 2013 National STFM Meeting: Lecture-Discussion
"Where's the Balance Between Service and

Education? – Survey Says…"

November 2015 Family Medicine Education Consortium: Seminar
"Taking Our Own Advice: Enhancing Engagement with NAS Through the Advising System"

April 2019 Society of Teachers of Family Medicine Annual Conference, Toronto, Ontario, CA Kenyon, T., Brehio, T., Sanborn, J., Morse, J., Brown, A. "Running Lapse: Interactive Modules for Measuring Specific Patient Safety and Professionalism

LICENSURE AND CERTIFICATION

April 2011 – Present	Advanced Life Support in Obstetrics Instructor
December 2004	Board Certified Family Physician
January 2004 – Present	Licensed by the NH Board of Medicine
May 2001 – Present	Advanced Cardiac Life Support Provider
June 2001 – Present	Neonatal Resuscitation Provider
June 2002 – Present	Advanced Life Support in Obstetrics Provider

AWARD

April 2018	Voted "Top Doc" for Family Medicine by NH Magazine, voted on by peers
April 2019	Voted "Top Doc" for Family Medicine by NH Magazine, voted on by peers
April 2020	Voted "Top Doc" for Family Medicine by NH Magazine, voted on by peers
April 2021	Voted "Top Doc" for Family Medicine by NH Magazine, voted on by peers

PUBLICATIONS

Hoffman AH, Brehio TL, Rosas S, Kohles SS, "The Effect of Bone Viscoelasticity on Protocols for Indentation Tests", Proceedings of the 1999 Bioengineering Conference, ASME, June 1999; Vol 42; 313-314

PROFESSIONAL DEVELOPMENT

Positive Power and Influence

Situational Leadership Course
Conflict Resolution Course

PROFESSIONAL MEMBERSHIPS

American Academy of Family Physicians
Society of Teachers of Family Medicine

PROFESSIONAL INTERESTS

Obstetrics, teen care, dermatology procedures and resident teaching

COMMUNITY ACTIVITIES

Researched, organized and implemented a Teen Clinic at Concord Hospital Family Health Center - Hillsboro-Deering

OUTSIDE INTERESTS AND ACTIVITIES

NASCAR stock car racing, Disney vacations, indoor soccer, softball, golf, reading, tap dancing, hip hop dancing, going on cruises, attending my children's sporting events, spending time with my husband, son and daughter

REFERENCES

Available on request

DOMINIC FRANCIS GEFFKEN

PROFESSIONAL

July 2017-present	Program Director NH Dartmouth Family Medicine Residency 250 Pleasant Street, Concord, NH 03301
July 2004-present	Director, Preventive Medicine NH Dartmouth Family Medicine Residency 250 Pleasant Street, Concord, NH 03301
August 2004-present	Director of Employee Health Concord Hospital 250 Pleasant Street, Concord, NH 03301

ACADEMIC APPOINTMENTS

July 2004-present	Assistant Professor of Community and Family Medicine, Geisel School of Medicine at Dartmouth
January 2008-present	Assistant Professor, The Dartmouth Institute, Geisel School of Medicine at Dartmouth
January 2012-present	Associate Program Director for Concord Hospital-Dartmouth Hitchcock Leadership Preventive Medicine Residency

EDUCATION

2002-2005	University of Massachusetts-Amherst Master of Public Health
July 1999- June 2004	University of Massachusetts Medical School-Worcester Family Medicine/Preventive Medicine Residency Program
1994-1999	University of Vermont College of Medicine M.D. awarded 1999
1982-1987	University of Vermont B.S. Biochemistry / B.A. English

CERTIFICATION

2007-2027	Diplomate American Board of Preventive Medicine
July 2004-present	Full License State of New Hampshire, Board of Medicine
2003-2023	Diplomate American Board of Family Practice
Nov. 2002-present	Full License Commonwealth of Massachusetts, Board of Registration in Medicine

CLINICAL EXPERIENCE

2004-present	Concord Hospital Family Health Center Provide comprehensive health care in a Family Practice clinic as a faculty member of a Family Medicine and Preventive Medicine residency.
1999-2004	Barre Family Health Center Provide comprehensive health care in a Family Practice clinic during my Family Medicine and Preventive Medicine residencies.
2002-2004	Worcester Polytechnic Institute (WPI) Student Health Center Provide primary health care to college students.
2003	Clark Student Health Center Provide primary health care to college students.

RESEARCH

March 1998-January 1999	Independent Research Project Russell Tracy, Ph.D., Edwin Bovill, MD. University of Vermont, College of Medicine, Department of Pathology. The association of exercise with the markers of inflammation in cardiovascular disease.
Summer 1995	Independent Research Project Melissa Perry, ScD. University of Vermont, College of Medicine, Department of Health Promotion. Characteristics of Vermont breast cancer mortality.
Spring Semester 1992	Behavior Modification Project John Burchard, Ph.D., University of Vermont, Department of Psychology. Implemented an in school behavior modification program to reduce the aggressive behavior in children.

HONORS/AWARDS

March 2017	NAMI New Hampshire 2017 Annual Award-Unsung Hero Awarded for integrated approach to behavioral health and primary care.
June 2006	Family Practice Role Model Award Award given by the residents in NH-Dartmouth Family Practice Residency to a faculty member.
July 2003-June 2004	Chief Resident. Preventive Medicine Residency Representative for the Preventive Medicine Residents in meetings with administration of the University of Massachusetts-Worcester Preventive Medicine Residency Program.
July 2001-June 2002	Chief Resident. Barre Family Health Center

Representative for the residents of the Barre Family Health Center in meetings with administration of the University of Massachusetts-Worcester Family Practice Residency Program.

November 1995 — Outstanding Research Award for Students
Awarded for presentation of summer research:
Characteristics of Vermont breast cancer mortality.
The Combined Primary Care Annual Meeting, Burl., VT.

PROFESSIONAL MEMBERSHIP

2004-present — American College of Preventive Medicine
Faculty Member

2003 — North American Primary Care Research Group
Faculty Member

1994-present — American Academy of Family Physicians
Faculty Member

1987-present — Sigma Xi. The Scientific Research Society.
Associate member

GRANTS

1998
Office of the Dean, University of Vermont College of Medicine and Department of Pathology, University of Vermont College of Medicine. Financial support to conduct research on association between physical activity and markers of inflammation in a healthy elderly population. Project published in American Journal of Epidemiology.

1995
Medical Alumni Association and Office of the Dean, University of Vermont College of Medicine. Financial support to conduct research on association of occupation and breast cancer mortality in the state of Vermont. Published in McGill Journal of Medicine.

PROFESSIONAL DEVELOPMENT

September 2009-June 2010 — National Institute for Program Director Development
Actively participated in 9-month series of courses to develop skills as a Family Medicine Residency Program Director

Jan. 2003-Jan. 2004 — Teaching of Tomorrow Workshops
Participated in workshops that fostered further development of teaching skills used in mentoring medical trainees.

COMMUNITY INVOLVEMENT

October 2016-present	Concord Coalition to End Homelessness-Board of Directors Member of board of directors for a non-profit, grass roots organization focused on a housing first model to reduce homelessness in Concord, NH.
2014-2015	The Downtown Clinic Assisted with implementation of a community-based clinic to allow greater access to healthcare for the homeless population in Concord, NH.
2011-present	Central New Hampshire Bicycling Coalition Working as part of a community coalition to increase walking and bicycling in the Greater Concord New Hampshire area.
2002	Steering Committee East Quabbin Alliance (EQUAL). Community group involved in assessment of community health needs and development and implementation of potential solutions.
Sept. 2002-June 2004	Medical Writer for column entitled "Health Matters". Write a biweekly medical column explaining common or current medical topics for a lay audience in local paper, The Barre Gazette
January 1997- June 1999	Free Clinic at Fletcher Allen Health Care Evaluated and treated people without medical insurance.
March 1998-June 1999	Free Clinic at The People's Health and Wellness Clinic Barre, VT. Evaluated and treated people without medical insurance.
1987-1995	Special Friends Program Howard Center for Human Services, Burlington, VT Spent time with an adolescent boy in a supportive, mentoring relationship.

PUBLICATIONS (Full List of Publications and Presentations available upon request)

Council, L.S., **Geffken, D.**, Valeras, A.B., Orzano, A.J, Rechisky, A., Anderson, S. A Medical Home: changing the way patients and teams relate through patient-centered care plans. Fam Syst Health 2012; 30: 190-198.

Eubank, D., **Geffken, D.**, Orzano, J., Ricci, R. Teaching Adaptive Leadership to Residents: What? Why? How? Fam Syst Health 2012; 30: 241-252.

Dysinger, W. S., King, V., Foster, T.S., **Geffken, D.F.** Incorporating population medicine into primary care residency training. Fam Med 2011; 43: 480-6.

Eubank, D., Orzano, J., **Geffken, D.**, Ricci, R. "Teaching team membership to family medicine residents: what does it take? Fam Syst Health 2011; 29: 29-43.

Majka DS, Chang RW, Vu TH, Palmas W, **Geffken DF**, Ouyang P, Ni H, Liu K.

Physical Activity and High-Sensitivity C-Reactive Protein: The Multi-Ethnic Study of Atherosclerosis. American Journal of Preventive Medicine 2009; 36: 56-62

Gunn W, **Geffken DF**. Complexity and Collaboration. In: Kessler R, Stafford D, eds. Collaborative Medicine Case Studies: Evidence in Practice. New York: Springer; 2008.

Geffken DF, Cushman M, Burke GL, Polak JF, Sakkinen PA, Tracy, RP. The association of physical activity and markers of inflammation in a healthy elderly population. American Journal of Epidemiology 2001; 153: 242-250.

Geffken DF, Perry M, Callas P. Association of occupation and breast cancer mortality in the state of Vermont, 1989-1993. McGill Journal of Medicine 2000; 5: 75-79.

Tracy RP, Rubin DZ, Mann KG, Bovill EG, Rand M, **Geffken DF**, Tracy PB. Thrombolytic therapy and proteolysis of factor V. Journal of the American College of Cardiology 1997; 30: 716-724.

Geffken DF, Keating FG, Kennedy MH, Cornell ES, Bovill EG, Tracy RP. The measurement of fibrinogen in population based research. Studies on instrumentation and methodology. Archives of Pathology and Laboratory Medicine 1994; 118: 1106-1109.

PRESENTATIONS

American College of Preventive Medicine. Prevention 2016. February 24-27, 2016 Washington, DC. Track Chair for Quality Improvement section of the meeting.

American College of Preventive Medicine. Prevention 2015. February 25-28, 2014 Atlanta, GA. Presenter 4-hour seminar entitled "Things I didn't learn in my QI training."

American College of Preventive Medicine. Prevention 2014. February 19-22, 2014 New Orleans, LA. Co-presenter of seminar with Ulfat Shaikh, MD, MPH,Helen Wu, PhD, Julia Logan, MD, MPH. Seminar entitled, "The ABC's of CQI: SMART, PDSA, VOC, RCA and Other Fun Stuff: An Introduction to Quality Improvement in Preventive Medicine."

American College of Preventive Medicine. Prevention 2014. February 19-22, 2014 New Orleans, LA. Co-moderator of panel discussion with David Shih, MD, MS. Panel discussion entitled, "Desperately Seeking Quality People: Education and Careers in Medical Quality and Patient Safety." Panelists were, Allen Leavens, MD, MPH, MS, P. Travis Harker, MD, MPH, and Beth Prairie, MD, MPH.

American College of Preventive Medicine. Preventive Medicine 2006. February 22-26, 2006, Reno, NV. Co-presenter with Paul Batalden, MD, Stephen Liu, MD, MPH, Quality Improvement Seminar entitled "Health Care Quality Improvement Institute- Improving Quality Improvement: Building and Sharing Best Evidence for Clinical Decision-making."

American Heart Association. 39th Annual Conference on Cardiovascular Disease Epidemiology and Prevention, March 24-27,1999. Orlando, FL. Poster Presentation: The association of physical activity and markers of inflammation in a healthy elderly population.

Sara L. Parker

[redacted]

OBJECTIVE: Interested in a position that will allow me to apply my existing skills while continuing to learn. Heavy interest in working for a community with diverse needs and focusing on patient and staff satisfaction while building bridges with external resources, partners, or affiliates.

EDUCATION/AWARDS:

John Stark High School
1996. Graduated with HS diploma

New England College, Henniker NH
1997-2000. Associates level degree in Business Administration. I have two semesters to complete B.A. I am planning to enroll in classes in the evening and over the internet. I am not your traditional student and view my education and the continuing of my education as an important ingredient in my overall success. I am interested in pursuing a Masters in Health Administration.

A&T Team Board Member
Hospital Association
2008-2013

Community Partner certified for Healthy Kids (NH State)
2002-2012

HICEAS Certified
2005-2010

Southern NH University
2021 – Current

NH Kiddos Award
Governor Lynch

CAREER SUMMARY:

ER Registration Supervisor, 2011- present

At the direction of the Patient Access Director, I collaborate with members of the Emergency Department, Primary Care Practices, Nursing, CEMA, Hospitalist, and Care Coordination to facilitate and maintain responsibility for organizational patient flow and capacity management while ensuring quality registration. This includes, but is not limited to operational, financial, clinical, performance improvement, program development, and customer relations and patient care outcomes. I have been the primary resource person for greater than 25 staff and provide direct support for staffing coverage needs and active codes during all shifts. Supports the Organization by fostering inter departmental communication/collaboration and patient advocacy while maintaining responsibility for organizational patient flow and capacity management.

Team Lead of Financial Counseling, 2002-2011

As Team Lead for Financial Counseling my role is to oversee the daily operations of the Dept and provide support for any areas of need. This role requires me to be dependable, work well under pressure, be an active listener, and maintain a positive attitude when under stress. I willingly accept these responsibilities and I work hard to meet the demands of this position and the evolution of our Department.

Assistant Director of Financial Aid, 1997-2002

Offer efficient and comprehensive service to all NEC students and their families seeking information and opportunities for financial aid. This encompasses all aspects of aid, scholarship, loans, work-study, honorary stipends, etc. To maximize opportunity for NEC to attract optimum number of candidates by presenting aid options and opportunities that may facilitate candidates' matriculation to NEC.

REFERENCES (Will provide contact information upon request):

Employment

Thomas Antinerella
Director of Patient Access
Concord Hospital

Michael Lynch, MD
Chief Medical Officer
Alice Day Peck Memorial Hospital

John Jarvis
Nurse Manager
Emergency Department

Sarah Kelly, PMP

[redacted]

Project Manager Specializing in Enterprise Healthcare IT Implementations

PMP-certified project manager with more than 10 years of healthcare experience. Project leader, providing oversight in a matrixed environment to staff of all levels. Management of projects from planning through implementation, responsible for all aspects of project management including:

- Develop project documentation, including: Charter, project plan, scope, timeline, and status reports.
- Lead large-scale technical and clinical transformation projects and programs.
- Plan and facilitate all activities throughout the project lifecycle.
- Ensure project deliverables are provided on time and on budget.
- Project implementation issue identification, management and resolution.
- Garner support of senior leadership team to ensure project success.

Professional Experience

Apr. 2018 – Present **Project Manager, Concord Hospital, Project Management Office**

- Management of clinical transformation projects as well as technical upgrades and maintenance for the enterprise electronic health record (EHR) used throughout all clinical and financial departments.
- Work with senior leadership team to adapt to changing priorities within a healthcare setting.
- Implementation of process and technical technology to support clinical transformation.
- Management of project teams greater than 40 ITS resources in size and including collaboration of administration, physicians and clinical team members.
- Mentoring and leadership for analysts, engineering and clinical team members to ensure project success.

Dec. 2009 – Apr. 2018 **App. Analyst/Project Manager, Concord Hospital, Physician Information Services**

- Implementation of an EHR for clinics, including workflow and system design, build and acceptance.
- Build and lead project teams comprised of multi-disciplinary team members, including leadership, physicians, nursing staff, ITS and support staff.
- Custom content and interface development, maintenance and testing for outpatient practices.

Feb. 2009 – Dec. 2009 **Supervisor, Concord Hospital, Patient Financial Services Pre-Services**

- Leadership and support for a team of 10 employees.
- Improvement of workflows to ensure payment of diagnostic testing and inpatient stays.
- Workflow modifications, using innovative approaches to technology in the financial setting.

May 2007 – Feb. 2009 **Training Specialist, Concord Hospital, Patient Financial Services Revenue Cycle**

- Provided training for hospital and clinic staff across healthcare enterprise.
- Developed and implemented training, policies and procedures related to revenue cycle processes.

Sept. 2004 – May 2007 **Research Asst & Clinical Interviewer, Dartmouth Psychiatric Research Center**

- Supported a multi-site research program serving older adults with serious mental illness.
- Interviewed and monitored research study participants.
- Developed and maintained documentation related to ensure funding and regulatory compliance.

Education

Bachelor of Arts in Psychology, **Project Management Professional (PMP),**

[redacted]

Suzanne Williams

EMPLOYMENT EXPERIENCE

Concord Hospital Family Health Center, *Concord, NH 03301*
Practice Manager
April 2008 – Current

- *Directs non-clinical office operations*
- *Business staff performance management*
- *Registration, charge entry and medical records management*
- *Supports and monitors department quality goals and initiatives*
- *Responsible for customer relations*
- *Ensures compliance with State, Local and Federal regulatory requirements*
- *Acts as a conduit for department and organizational communication*

CIGNA HealthCare of New Hampshire, *Hooksett, NH 03106*
Employer Services Operations Manager
January 2001 – April 2008

Member Services Manager
August 1998 – December 2000

Member Services Supervisor
May 1996 – August 1998

Member Services Team Leader
September 1995 – May 1996

Member Services Representative
February 1991 – September 1995

Welcome Plan Representative
September 1988 – February 1991

EDUCATION

Franklin Pierce College*, Concord, NH 03301*
1998-2000 Business Management

5/19/2022

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary Amount Paid from this Contract
Sara Parker, Practice Manager Sue Williams, Practice Manager Vacant, Assistant Practice Manager Amanda DeCook, FMR Data Analyst Sarah Kelly, FHC/FMR Administrative Director	Practice Leadership	FY22: $1,035 FY23: $5,313.82 FY24: $5,313.82
Candice Moore Carianne Wood Denise Hollen Erin McKay Felicia Alves Heather Byrd Janice White Katie Richard Mary Dussault Radhika Sharma Todd Magee Ann Marie Silvernail Catherine Larochelle Lorrie Buxton Nadean Byers Suzanne Richard	Certified Medical Assistant	FY22: $3,368 FY23: $57,318 FY24: $57,318
Rachel Wainaina Emma Macdonald Michele Gilman	Practice Medical Assistant	FY22: $557 FY23: $6,974 FY24: $6,974
Angela Ballantine Antonia McKerley Barbara Ward Vacant Deborah Martin Vacant Emily Miller MaryRose Burrows Melanie Fees Stephen Suba Janet Paige Patricia Montray Susan Borruso Taylor Flynn	Practice Patient Care Coordinator	FY22: $2,695 FY23: $42,450 FY24: $42,450
Dipak Prasad	Family Health Center Medical Liason (Interpreter)	FY22: $196 FY23: $3,098.15 FY24: $3,098.15
Emily Bogle Vacant Vacant	FHC Nurse Care Coordinator	FY22: $1,025 FY23: $14,558.74 FY24: $14,558.74
Jennifer Coyle	Registered Nurse	FY22: $2,759

Lindsay Balch Mikayla Panacopoulous Min Sobozenski Mina Dhamala-Thatal Alexa Kerry Vacant Vacant Vacant		FY23: $34,714 FY24: $34,714
Sarah Healey Vacant	FHC Nurse Clinical Management	FY22: $373 FY23: $5,733.56 FY24: $5,733.56
Emma Donzello-Jewett Jennifer Abbot Shelby Swanick	FHC Resource Nurse	FY22: $1,233 FY23: $6,140.35 FY24: $6,140.35
Andrew Valeras Ana Castellanos Mendez Angela Yerdon McLeod Craig Betchart Cynthia King Ellen Plumb Jay B Bannister Linda Haller Tamara Shilling Viking Hedberg Teri Brehio Dom Geffken Vacant	Physician Faculty	FY22: $2,498 FY23: $5,570.75 FY24: $5,570.75
Carlie Ingram Patricia Cousens	Practice Physician Assistant	FY22: $295 FY23: $1,463.11 FY24: $1,463.11
Jonathan Attias Jenny Lane	Practice APRN	FY22: $235 FY23: $1,111.27 FY24: $1,111.27
Angela Phillips Kiersten Scarponi Lauren Kennedy Tara Davis-Thompson Vacant	Integrated Behavioral Health Clinician	FY22: $1,872 FY23: $31,723.27 FY24: $31,723.27

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-04)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Coos County Family Health Services, Inc.		1.4 Contractor Address 54 Willow St. Berlin, NH 03570	
1.5 Contractor Phone Number (603) 752-3669	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $731,721
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Ken Gordon 3707CC35CA8C40C... Date: 5/25/2022		1.12 Name and Title of Contractor Signatory Ken Gordon CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt D718BB63E970AC7... Date: 5/25/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPH	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Takhmina Rakhmatova FDF321C625C44AC... On: 5/27/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

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Date 5/25/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Tele-Psychiatric Consultation, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Wellness Visits, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Breastfeeding, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any

period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

Exhibit C-1, Budget

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Coos County Family Health Services, Inc.*

Budget Request for: *Primary Care Services*

Budget Period *Date of G&C Approval - 6/30/22 (SFY 22)*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$24,682
2. Fringe Benefits	$4,587
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$29,269
Total Indirect Costs	$0
TOTAL	**$29,269**

Contractor Initials ps

Date 5/25/2022

Exhibit C-2, Budget

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Coos County Family Health Services, Inc.*
Budget Request for:	*Primary Care Services*
Budget Period	*7/1/22 - 6/30/23 (SFY 2023)*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$270,849
2. Fringe Benefits	$80,377
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$351,226
Total Indirect Costs	$0
TOTAL	**$351,226**

Contractor Initials DS

Date 5/25/2022

Exhibit C-3, Budget

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Coos County Family Health Services, Inc.*
Budget Request for:	*Primary Care Services*
Budget Period	*7/1/23 - 6/30/24 (SFY 2024)*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$270,849
2. Fringe Benefits	$80,377
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$351,226
Total Indirect Costs	$0
TOTAL	**$351,226**

Contractor Initials ps

Date 5/25/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

Vendor Initials DS

Date 5/25/2022

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

DocuSigned by:
Ken Gordon
3707CC55CAAC49C...

5/25/2022
Date

Name: Ken Gordon
Title: CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements).and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

DocuSigned by:
Ken Gordon
3707CC55CAAC4DC...

5/25/2022
Date

Name: Ken Gordon
Title: CEO

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials DS

Date 5/25/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/25/2022
Date

DocuSigned by:
Ken Gordon
3707CC55CAAC4DC...
Name: Ken Gordon
Title: CEO

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

5/25/2022
Date

DocuSigned by:
Ken Gordon
3707CC35CAAC40C...
Name: Ken Gordon
Title: CEO

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Ken Gordon
37DFCC30CAAC4DC...

5/25/2022
Date

Name: Ken Gordon
Title: CEO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) **Definitions**.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Coos County Family Health Services
The State	Name of the Contractor
Iain Watt	Ken Gordon
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Ken Gordon
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	CEO
Title of Authorized Representative	Title of Authorized Representative
5/25/2022	5/25/2022
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
[signature]

5/25/2022
Date

Name: Ken Gordon
Title: CEO

Contractor Initials KG
Date 5/25/2022

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 1673855090000

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

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e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening and Referrals for SDOH

Enabling Services Work Plan Agency Name: Coos County Family Health Services Name and Role of Person(s) Completing Work Plan: Cindy Charest, RN, Chief Quality Officer			
Enabling Services Focus Area: Social Determinates of Health Screening Tools			
Project Goal: Integrate the use of a standardized SDOH Screening tool in our Clinical Practice			
Project Objective: Identify an Appropriate SDOH Screening Tool for Use in Our Clinical Practice			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Select screening tool and develop appropriate workflow	CMO, CQO, Provider, Nurses, CCMA	Perform chart audits/crystal reports to determine use of screening tool Share audit reports with QI Committee Report to Board of Directors Recommend c01Tective action to increase use of tool/provide care to patients Update EMR templates to imbed screening tool and capture data Offer trainings to update staff on implementation of tool and EMR changes	April 30, 2022
Provide training and education about responsibilities to staff, assuring new staff are also trained	CQO, Nurse Manager, Nurses, IT		May 30, 2022
Communicate to each staff member his or her responsibilities	COO, CQO, Nurse Manager		June 30, 2022
Determine resources available in the community	Social Worker, CHW		June 30, 2022
Distribute SDOI-I screening tool to patient by mail or upon arrival	Reception Staff, Nurses, CCMAs		July 15, 2022
Make educational materials and/or resources available in exam rooms	Nurses, CCMAs, Providers		July 15, 2022
Review the completed SDOH screening tool and determine patient needs; incorporate into the plan of care for the patient	Providers, Nurses		July 15, 2022
Refer patients to additional team members for education, as needed	Providers, Nurses		July 15, 2022

Attachment #1 – Screening and Referrals for SDOH

Facilitate referrals to community resources based on patient needs	Providers, Nurses, Social Worker, CHW		July 15, 2022

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise, and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** Yes No	

Attachment #1 – Screening and Referrals for SDOH

January 2023 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** ___ Yes ___ No	

Attachment #1 – Screening and Referrals for SDOH

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	__ Yes __ No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** __ Yes __ No	
July 2023 Project Update **SFY23 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #1 – Screening and Referrals for SDOH

January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Attachment #1 – Screening and Referrals for SDOH

Work Plan Revisions submitted: Yes No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	__ Yes -- No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 – Tele-Psychiatric Consultation

Enabling Services Work Plan Agency Name: Coos County Family Health Services Name and Role of Person(s) Completing Work Plan: Cindy Charest, RN, Chief Quality Officer			
Enabling Services Focus Area: Tele-Psychiatric Consultation			
Project Goal: Enhance BH integration for women/children through the use of teleconsultation with a psychiatric nurse practitioner.			
Project Objective: Conduct an 18-month trial using a psychiatric nurse practitioner to address the BH needs of our patients.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Hire full time psych nurse practitioner	CMO, CEO, COO, BH Team	Perform chart audits/crystal reports to determine variation in BH telehealth visits Share audit reports with QI Committee Report to Board of Directors Update EMR templates as needed Leadership to provide support to ensure compliance with goal	April 30, 2022
Provide training to additional staff regarding telehealth visits, assuring new staff are also	Nurse Manager, Nurses, IT Team		April 30, 2022
Communicate to each staff member his or her responsibilities	COO, CMO, Nurse Manager		April 30, 2022
Facilitate referrals to community resources based on patient needs	Providers, Nurses, CCMAs, Social Worker, CHW		April 30, 2022

Attachment #2 – Tele-Psychiatric Consultation

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the actiVities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** ___ Yes ___ No	
January 2023 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** ___ Yes ___ No	

Attachment #2 – Tele-Psychiatric Consultation

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	___ Yes No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** ___ Yes ___ No	
July 2023 Project Update **SFY23 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in pta e.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

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Attachment #2 – Tele-Psychiatric Consultation

Work Plan Revisions submitted: Yes No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July 2024 Project Update **SFY24 Narrative:** If met–Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 – Adolescent Well Visits

Quality Improvement Work Plan
Agency Name: Coos County Family Health Services
Name and Role of Person(s) Completing Work Plan: Cindy Charet, RN, Chief Quality Officer

MCH Performance Measure: Adolescent Well-Visits Project Objective: To increase the% of adolescents, ages 12 - 21 who had at least 1 comprehensive well-care visit/CPE during the measurement year.

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Clinic nurse to electronically track WCV for adolescents	Nurses, CCMAs	Perform reports/audit review to determine percentage of adolescents with an annual WVC	March 30, 2022
Clinic nurse will send a reminder for annual visit via secure email, letter, or phone	Reception, Nurses, CCMAs	Share audit results with staff/QI Committee	March 30, 2022
Clinic nurse will contact parent/legal guardian/patient for overdue services	Nurses, CCMAs	Report to Board of Directors Recommend corrective action activities to improve compliance with goal	March 30, 2022
An appointment will be made 366 days per last annual WCV at the time of visit or reception will call	Reception	Update EMR templates as needed.	March 30, 2022
Parent/guardian/patient will receive a clinical summary that will include all future appointments	Reception, Nurses, CCMAs	Leadership to provide support to ensure compliance with goal	March 30, 2022
Care Management will review insurance portals for due/over due services at least quarterly and notify medical teams	Care Management, Nurses, CCMAs		March 30, 2022
Medical teams will involve social worker if barriers of care identified	Providers, Nurses, CCMAs, Social Worker		March 30, 2022

Attachment #4 – Adolescent Well Visits

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes ___ No	
January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes ___ No	
July 2023 Project Update	

Attachment #4 – Adolescent Well Visits

SFY23 Outcome (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	Yes No
July 2023 Project Update **SFY23 Narrative:** If met–Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** ___ Yes ___ No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** Yes No	
July 2024 Project Update **SFY24 Outcome (insert your agency's data/outcome results here for 7/1/23- 6/30/24)**	
Did you meet your Target/Objective?	Yes No
July 2024 Project Update	

Attachment #4 – Adolescent Well Visits

SFY24 Narrative: If met–Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year	

Attachment #5 – Breastfeeding

Quality Improvement Work Plan

Agency Name: Coos County Family Health Services

MCH Performance Measure: Breastfeeding

Project Objective: To increase the % of infants who are ever breastfed during the measurement year.

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Imbed a lactation consultant specialist position in the practice	Lactation consultant, CEO, CMO, COO	Perform reports/audit review to determine percentage of infants breastfed	March 30, 2022
Develop workflow for referral process to lactation consultant	Lactation consultant, COO, Nurse Manager	Share audit results with staff/QI Committee Report to Board of Directors Update EMR templates as needed Leadership to provide support to ensure compliance with goal	April 30, 2022
Prenatal staff inform patients about consultant role and services	Providers, Nurses, CCMAs, Social Worker, CHW		April 30, 2022
Ensure prenatal staff discuss options available with expectant mothers	Providers, Nurses		May 30, 2022
Offer educational materials to patients	Providers, Nurses, CCMAs, Social Worker		April 30, 2022

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Attachment #5 – Breastfeeding

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
July 2023 Project Update	

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Attachment #5 – Breastfeeding

SFY23 Outcome (insert your organization's data/outcome Results here for 7/1/22-6/30/23). Did you meet your Target/Objective? Yes No **July 2023 Project Update** **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** Yes No	

Attachment #5 – Breastfeeding

January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, Evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** ___ Yes ____ No **July 2024 Project Update** **SFY24 Outcome (insert your agency's data/outcome results here for 7/1/23-6/30/24)** Did you meet Your Target Objective? ___ Yes ____ No **July 2024 Project Update**	___ Yes -- No
SFY24 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year	

Contractor Initials DS

Date 5/25/2022

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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5/25/2022

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS

5/25/2022

State of New Hampshire

Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that COOS COUNTY FAMILY HEALTH SERVICES, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on December 14, 1979. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **63204**

Certificate Number : **0005748428**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this **2nd** day of **April** A.D. **2022**.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Pauline Tibbetts, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Coos County Family Health Services
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on January 20, 2022, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Ken Gordon, CEO (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Coos County Family Health Services to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority remains valid for thirty (30) days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 5/17/2022

Pauline M. Tibbetts
Signature of Elected Officer
Name: Pauline Tibbetts
Title: Board Secretary

DocuSign Envelope ID: 24A2E836-8D72-4767-BA3E-6803DC377095

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/26/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER FIAI/Cross Insurance 1100 Elm Street Manchester NH 03101	CONTACT NAME: Michele Palmer PHONE (A/C, No, Ext): (603) 669-3218 FAX (A/C, No): (603) 645-4331 E-MAIL ADDRESS: manch.certs@crossagency.com
INSURED Coos County Family Health Services, Inc. 133 Pleasant Street Berlin NH 03570-2006	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Philadelphia Indemnity Ins Co — 18058 INSURER B: MEMIC Indemnity Company — 11030 INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: 21-22 All lines REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☒ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:			PHPK2286106	07/01/2021	07/01/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 20,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY ☒ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY			PHPK2286107	07/01/2021	07/01/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	☒ UMBRELLA LIAB ☒ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☒ RETENTION $ 10,000			PHUB771756	07/01/2021	07/01/2022	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		3102802240 (3a.) NH	07/01/2021	07/01/2022	☒ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
A	Employee Dishonesty			PHPK2286106	07/01/2021	07/01/2022	Limit	500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Refer to policy for exclusionary endorsements and special provisions.

CERTIFICATE HOLDER

State of NH Department of Health & Human Services
129 Pleasant Street
Concord NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

coös county
Family Health

54 Willow Street
Berlin, NH 03570-1800
Ph: 1-603-752-3669
Fax: 1-603-752-3027

133 Pleasant Street
Berlin, NH 03570-2006
Ph: 1-603-752-2040
Fax: 1-603-752-7797

2 Broadway Street
Gorham, NH 03581-1597
Ph: 1-603-466-2741
Fax: 1-603-466-2953

59 Page Hill Road
Berlin, NH 03570-3568
Ph: 1-603-752-2900
Fax: 1-603-752-3727

MISSION OF
COÖS COUNTY FAMILY HEALTH SERVICES

Improving the health and wellbeing of our community through the provision of health and social services of the highest quality.

VISION OF
COÖS COUNTY FAMILY HEALTH SERVICES

Creating a healthier future through education, prevention and access to care.

VALUES OF
COÖS COUNTY FAMILY HEALTH SERVICES

Respect	We treat everyone in our community - patients, their families and our colleagues with dignity and respect regardless of their income, social status, race, religion or other factors.
Integrity	Adhere to the highest standards of professionalism, ethics and personal responsibility.
Compassion	Provide the best care, treating patients and family members with sensitivity and empathy.
Healing	Inspire hope and nurture the well-being of the whole person, respecting their physical, emotional and spiritual needs.
Teamwork	Value the contributions of all, blending the skills of individual staff members and community members for the benefit of all.
Innovation	Infuse and energize the organization, enhancing the lives of those we serve through the creative ideas and unique talents of each employee.
Excellence	Deliver the best outcomes and highest quality service through the dedicated efforts of every team member.
Stewardship	Sustain and reinvest in our mission by wisely managing our human, natural and material resources.

(Mission Statement)
Board Approved 1/20/2022

BerryDunn

coös county
Family Health

FINANCIAL STATEMENTS

June 30, 2021 and 2020

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Coos County Family Health Services, Inc.

We have audited the accompanying financial statements of Coos County Family Health Services, Inc., which comprise the balance sheets as of June 30, 2021 and 2020, and the related statements of operations, functional expenses, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Coos County Family Health Services, Inc. as of June 30, 2021 and 2020, and the results of its operations, changes in its net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, during the year ended June 30, 2021, Coos County Family Health Services, Inc. adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, and related guidance. Our opinion is not modified with respect to this matter.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
September 16, 2021

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Balance Sheets

June 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 7,646,760	$ 7,218,115
Patient accounts receivable	1,047,495	1,523,938
Grants receivable	493,691	537,300
Other current assets	231,736	190,096
Total current assets	9,419,682	9,469,449
Investments	819,550	817,796
Assets limited as to use	561,558	600,630
Beneficial interest in funds held by others	33,867	28,564
Property and equipment, net	2,140,410	2,307,968
Total assets	$12,975,067	$13,224,407

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and accrued expenses	$ 215,702	$ 284,133
Accrued payroll and related expenses	1,201,736	1,167,190
Deferred revenue	578,000	582,769
Medicare accelerated payments	-	633,807
Paycheck Protection Program refundable advance	-	1,718,500
Total current liabilities and total liabilities	1,995,438	4,386,399
Net assets		
Without donor restrictions	10,888,194	8,734,202
With donor restrictions	91,435	103,806
Total net assets	10,979,629	8,838,008
Total liabilities and net assets	$12,975,067	$13,224,407

The accompanying notes are an integral part of these financial statements.

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Statements of Operations

Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenue		
Patient service revenue	**$10,274,683**	$11,101,416
Provision for bad debts	**-**	(353,736)
Net patient service revenue	**10,274,683**	10,747,680
Grants, contracts, and contributions	**5,162,451**	3,659,117
Provider Relief Funds	**-**	642,109
Paycheck Protection Program	**1,718,500**	-
Other operating revenue	**142,613**	90,856
Net assets released from restriction for operations	**33,606**	35,977
Total operating revenue	**17,331,853**	15,175,739
Operating expenses		
Salaries and wages	**8,474,218**	8,258,331
Employee benefits	**1,926,341**	2,457,447
Contract services	**832,034**	420,751
Program supplies	**606,073**	483,916
340B program expenses	**967,246**	1,074,646
Occupancy	**512,818**	389,234
Other operating expenses	**1,344,660**	1,116,682
Depreciation	**262,875**	271,795
Total operating expenses	**14,926,265**	14,472,802
Income from operations	**2,405,588**	702,937
Other revenue and gains		
Investment income	**23,296**	29,538
Change in fair value of investments	**(15,266)**	22,076
Total other revenue and gains	**8,030**	51,614
Excess of revenue over expenses and increase in net assets without donor restrictions	**$ 2,413,618**	$ 754,551

The accompanying notes are an integral part of these financial statements.

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Statements of Functional Expenses

Years Ended June 30, 2021 and 2020

	2021		
	Healthcare Services	Administration and Support Services	Total
Salaries and wages	$ 7,414,941	$ 1,059,277	$ 8,474,218
Employee benefits	1,685,549	240,792	1,926,341
Contract services	656,133	175,901	832,034
Program supplies	606,073	-	606,073
340B program expenses	967,246	-	967,246
Occupancy	448,716	64,102	512,818
Other operating expenses	1,176,579	168,081	1,344,660
Depreciation	230,016	32,859	262,875
Total operating expenses	$ 13,185,253	$ 1,741,012	$ 14,926,265

	2020		
	Healthcare Services	Administration and Support Services	Total
Salaries and wages	$ 7,236,720	$ 1,021,611	$ 8,258,331
Employee benefits	2,125,731	331,716	2,457,447
Contract services	277,708	143,043	420,751
Program supplies	485,972	-	485,972
340B program expenses	1,074,646	-	1,074,646
Occupancy	341,086	48,148	389,234
Other operating expenses	976,747	137,879	1,114,626
Depreciation	238,174	33,621	271,795
Total operating expenses	$ 12,756,784	$ 1,716,018	$ 14,472,802

The accompanying notes are an integral part of these financial statements.

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Statements of Changes in Net Assets

Years Ended June 30, 2021 and 2020

	2021	2020
Net assets without donor restrictions		
Excess of revenue over expenses and increase in net assets without donor restrictions	$ 2,413,618	$ 754,551
Net assets with donor restrictions		
Grants, contracts, and contributions	15,932	33,657
Net assets released from restriction for operations	(33,606)	(35,977)
Change in fair value of beneficial interest in funds held by others	5,303	2,019
Decrease in net assets with donor restrictions	(12,371)	(301)
Change in net assets	2,401,247	754,250
Net assets, beginning of year	8,838,008	8,083,758
Cumulative effect adjustment from adoption of Accounting Standards Update No. 2014-09	(259,626)	-
Net assets, end of year	$10,979,629	$ 8,838,008

The accompanying notes are an integral part of these financial statements.

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Statements of Cash Flows

Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	**$ 2,401,247**	$ 754,250
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	**262,875**	271,795
Change in fair value of investments	**15,266**	(22,076)
Change in fair value of beneficial interest in funds held by others	**(5,303)**	(2,019)
(Increase) decrease in the following assets		
Patient accounts receivable	**216,817**	97,265
Grants receivable	**43,609**	(46,895)
Other current assets	**(41,640)**	(61,659)
Increase (decrease) in the following liabilities		
Accounts payable and accrued expenses	**(68,431)**	22,421
Accrued payroll and related expenses	**34,546**	325,363
Deferred revenue	**(4,769)**	476,269
Medicare accelerated payments	**(633,807)**	633,807
Paycheck Protection Program refundable advance	**(1,718,500)**	1,718,500
Net cash provided by operating activities	**501,910**	4,167,021
Cash flows from investing activities		
Proceeds from sales of investments	**177,101**	252,129
Purchase of investments	**(194,121)**	(272,025)
Capital acquisitions	**(95,317)**	(206,847)
Transfer of endowment contributions to perpetual trust held by others	**-**	(850)
Net cash used by investing activities	**(112,337)**	(227,593)
Net increase in cash and cash equivalents and restricted cash	**389,573**	3,939,428
Cash and cash equivalents and restricted cash, beginning of year	**7,818,745**	3,879,317
Cash and cash equivalents and restricted cash, end of year	**$ 8,208,318**	$ 7,818,745
Breakdown of cash and cash equivalents and restricted cash, end of year		
Cash and cash equivalents	**$ 7,646,760**	$ 7,218,115
Assets limited as to use	**561,558**	600,630
	$ 8,208,318	$ 7,818,745

The accompanying notes are an integral part of these financial statements.

Organization

Coos County Family Health Services, Inc. (the Organization) is a not-for-profit corporation organized in New Hampshire. The Organization is a Federally Qualified Health Center (FQHC) which provides outpatient health care, dental and disease prevention services to residents of Coos County, New Hampshire, through direct services, referral and advocacy.

1. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Organization have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which requires the Organization to report information in the financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of the Organization's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

The Organization is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, the Organization is exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the financial statements.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the State of New Hampshire and the Center for Disease Control, the Organization took steps to create safe distances between both staff and patients. Medical and behavioral health patient visits were done through telehealth when appropriate.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services (HHS). The Organization received PRF in the amount of $642,109 during the year ended June 30, 2020. These funds were to be used for qualifying expenses and to cover lost revenue due to COVID-19 through June 30, 2021. The PRF are considered contributions and are recognized as income when qualifying expenditures or lost revenues have been incurred. The Organization incurred qualifying revenue losses of $642,109 during the year ended June 30, 2020. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, the amount of income allowed to be recognized may change. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

On April 13, 2020, the Organization received a loan in the amount of $1,718,500 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration under the CARES Act and the PPPHCE Act. The principal amount of the PPP was subject to forgiveness, upon the Organization's request, to the extent that the proceeds were used to pay qualifying expenditures, including payroll costs, rent and utilities, incurred by the Organization during a specific covered period. The Organization followed the conditional contribution model to account for the PPP and recognized the full amount of the PPP as revenue after receiving notification of full forgiveness in May 2021.

In response to the COVID-19 pandemic, the Center for Medicare and Medicaid Services (CMS) made available an accelerated and advance payment program to Medicare providers. The Organization requested payment equal to 100% of a three month claim period. Under the program, CMS would begin recouping payment from claim payments 120 days after the advance was made; however, the Organization repaid the accelerated payments in full in July 2020.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less.

The Organization has cash deposits in major financial institutions which exceed federal depository insurance limits. The Organization has not experienced losses in such accounts and management believes the credit risk related to these deposits is minimal.

Revenue Recognition and Patient Accounts Receivable

The Organization has adopted Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance, which supersedes accounting standards that previously existed under U.S. GAAP and provides a single revenue model to address revenue recognition to be applied by all companies. Under the new standard, companies recognize revenue when a customer obtains control of promised goods or services in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. Topic 606 also requires companies to disclose additional information, including the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The Organization adopted this ASU for the year ended June 30, 2021 and elected the modified retrospective method; therefore, the financial statements and related notes have been presented accordingly. Under the modified retrospective method, the cumulative effect of applying the standard was recognized at the date of initial application and resulted in a decrease in net assets without donor restrictions of $259,626, recording a decrease in patient accounts receivable in the same amount.

The adoption of Accounting Standards Codification (ASC) Topic 606 changed the timing of when the Organization recognizes revenue from contract pharmacy services with Wal-Mart Stores, Inc. from the date on which a drug is dispensed to a patient to when the dispensed drug is reordered and shipped to the pharmacy. The adoption of Topic 616 also changed how implicit price concessions are presented in the financial statements. Under the previous standards, the estimate for amounts not expected to be collected based upon historical experience was reflected as a provision for doubtful accounts, and presented separately as an offset to net patient service revenue. Under the new standards; the estimate for amounts not expected to be collected based on historical experience will continue to be recognized as a reduction to net revenue, but not reflected separately as provision for doubtful accounts.

The impact of the adoption on the Organization's financial statement line items from adoption of Topic 606 was as follows:

	Balances without the Adoption of Topic 606	Adjustments Due to Topic 606	As Reported June 30, 2021
Balance sheet			
Patient accounts receivable	$ 1,307,121	$ (259,626)	$ 1,047,495
Net assets without donor restrictions	11,147,820	(259,626)	10,888,194

	Restated July 1, 2020	June 30, 2021
Patient accounts receivable	$ 1,264,312	$ 1,047,495
Net assets without donor restrictions	8,474,576	10,888,194

	As Reported	Balance Without Topic 606 Adoption	Effect of Change
Statement of operations			
Patient service revenue	$ 10,274,683	$ 10,497,699	$ (223,016)
Provision for bad debts	-	(223,016)	223,016
Net patient service revenue	$ 10,274,683	$ 10,274,683	$ -

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payers (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Organization. The Organization measures the performance obligation for medical, behavioral health and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Organization measures the performance obligation for contract pharmacy services with Wal-Mart Stores, Inc. (Walmart) based on when the drug dispensed to the patient has been reordered and shipped to Walmart by the Organization's Pharmacy Benefits Manager as the Organization is not entitled to payment until Walmart has been made whole for the drugs it dispensed to the patient. The Organization measures the performance obligation for contract pharmacy services with Walgreens Co. based on when the prescription is dispensed to the patient. The Organization's performance obligations are thus satisfied at a point in time.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Organization's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience.

Consistent with the Organization's mission and FQHC designation, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Organization expects to collect based on its collection history with those patients.

The Organization has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payer. In assessing collectability, the Organization has elected the portfolio approach. The portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers (patients). The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payer or group of payers will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. Payer concentrations are disclosed in Note 7.

The Organization bills the patients and third-party payers several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Organization is primarily reimbursed for medical and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Medicaid

The Organization is primarily reimbursed for medical and ancillary services based on prospectively set rates for an encounter furnished to a Medicaid beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Dental and certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Other Payers

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Organization is reimbursed for services based on contractually obligated payment rates for each Current Procedural Terminology code, which may be less than the Organization's public fee schedule.

Patients

The Organization provides care to patients who meet certain criteria under its sliding fee discount program. The Organization estimates the costs associated with providing this care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for the sliding fee discount program. The estimated cost of providing services to patients under the Organization's sliding fee discount program was approximately $445,680 and $489,255 for the years ended June 30, 2021 and 2020, respectively. The Organization is able to provide these services with a component of funds received through federal grants.

For uninsured patients who do not qualify under the Organization's sliding fee discount program, the Organization bills the patient based on the Organization's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

340B Pharmacy Program Revenue

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. This program requires drug manufacturers to provide outpatient drugs to FQHCs and other covered entities at a reduced price. The Organization contracts with other local pharmacies under this program. The contract pharmacies dispense drugs to eligible patients of the Organization and bill commercial insurances on behalf of the Organization. Reimbursement received by the contract pharmacies is remitted to the Organization, less dispensing and administrative fees. The dispensing and administrative fees are costs of the program and not deemed to be implicit price concessions which would reduce the transaction price. The Organization recognizes revenue in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription after the amount has been determined by the pharmacy benefits manager.

Laws and regulations governing the Medicare, Medicaid and 340B programs are complex and subject to interpretation. Management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare, Medicaid and 340B programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. The accounts receivable from patients and third-party payers, net of contractual allowances, were as follows:

	2021	2020
Governmental plans		
Medicare	29 %	30 %
Medicaid	18 %	21 %
Commercial payers		
Anthem Blue Cross Blue Shield	15 %	11 %
Other commercial payers	28 %	23 %
Patient	10 %	15 %
Total	100 %	100 %

Patient accounts receivable consisted of the following as of June 30:

	2021	2020
Medical and dental patient accounts receivable	$ 864,014	$ 889,002
Contract 340B pharmacy program receivables	183,481	634,936
Patient accounts receivable, net	$ 1,047,495	$ 1,523,938

Grants Receivable

Grants receivable are stated at the amount management expects to collect from outstanding balances. All such amount are considered collectible.

The Organization receives a significant amount of grants from HHS. As with all government funding, these grants are subject to reduction or termination in future years. For the years ended June 30, 2021 and 2020, respectively, grants from HHS (including both direct awards and awards passed through other organizations) represented approximately 68% and 67% of grants, contracts, and contributions.

A portion of the Organization's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Organization has met the performance requirements or incurred expenditures in compliance with specific contract or grant provisions, as applicable. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue.

The Organization has been awarded cost reimbursable grants from HHS that have not been recognized at June 30, 2021 because qualifying expenditures have not yet been incurred as follows:

	Amount	Available Through
Health Center Program	$ 1,834,070	May 31, 2022
American Rescue Plan Act Funding for Health Centers	3,362,625	March 31, 2023
Total HHS grant funds available	$ 5,196,695	

Investments

The Organization reports investments at fair value. Investments include assets held for long-term purposes. Accordingly, investments have been classified as non-current assets on the accompanying balance sheets regardless of maturity or liquidity. The Organization has established policies governing long-term investments.

The Organization has elected the fair value option for valuing its investments, which consolidates all investment performance activity within the other revenue and gains section of the statements of operations. The election was made because the Organization believes reporting the activity as a single amount provides a clearer measure of the investment performance.

Investment income and the change in fair value are included in the excess of revenue over expenses, unless otherwise stipulated by the donor or State Law. Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility risks. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

Assets Limited as to Use

Assets limited as to use include cash and cash equivalents designated by the Board of Directors for future working capital needs and donor-restricted grants and contributions.

Beneficial Interest in Funds Held by Others

The Organization is a beneficiary of an agency endowment fund at The New Hampshire Charitable Foundation (the Foundation). Pursuant to the terms of the resolution establishing the fund, property contributed to the Foundation is held as a separate fund designated for the benefit of the Organization. In accordance with its spending policy, the Foundation makes distributions from the fund to the Organization. The distributions are approximately 4% of the market value of the fund per year. The Organization's interest in the fund is recognized as net assets with donor restrictions.

Property and Equipment

Property and equipment are carried at cost, less accumulated depreciation. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. The Organization's capitalization policy is applicable for acquisitions greater than $5,000.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restriction. Contributions whose restrictions are met in the same period as the support was received are recognized as net assets without donor restrictions.

Donated Goods and Services

The Organization acts as a conduit for pharmaceutical company patient assistance programs. The Organization provides assistance to patients in applying for and distributing prescription drugs under the programs. The value of the prescription drugs distributed by the Organization to patients is not reflected in the accompanying financial statements. The Organization estimates that the value of prescription drugs distributed by the Organization for the years ended June 30, 2021 and 2020 was $2,317,558 and $1,534,312, respectively.

Various programs' help and support for the daily operations of the Organization's Response Program were provided by the general public of the surrounding communities. The donated services have not been reflected in the accompanying financial statements because they do not meet the criteria for recognition (specialized skills that would be purchased if not donated). Management estimates the fair value of donated services received but not recognized as revenues was $144,606 and $144,639 for the years ended June 30, 2021 and 2020, respectively. The Response Program also receives donated supplies to be used for program activities. The fair value of supplies recognized as revenues was $2,560 and $2,056 for the years ended June 30, 2021 and 2020, respectively.

Functional Expenses

The financial statements report certain categories of expenses that are attributable to more than one program or supporting function; therefore, these expenses require allocation on a reasonable basis that is consistently applied. As the Organization is a service organization, such expenses are allocated between healthcare services and administrative support based on the percentage of direct care wages to total wages.

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through September 16, 2021, the date that the financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

2. Availability and Liquidity of Financial Assets

The Organization regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents, investments and a line of credit.

The Organization had working capital of $7,424,244 and $5,083,050 at June 30, 2021 and 2020, respectively. The Organization had average days (based on normal expenditures) cash on hand (including investments and assets limited as to use for working capital) of 223 and 204 at June 30, 2021 and 2020, respectively.

Financial assets available for general expenditure within one year were as follows:

	2021	2020
Cash and cash equivalents	$ 7,646,760	$ 7,218,115
Patient accounts receivable, net	1,047,495	1,523,938
Grants receivable	493,691	537,300
Investments	819,550	817,796
Assets limited as to use for working capital	503,990	525,388
Less Medicare accelerated payments repaid in July 2020	-	(633,807)
Financial assets available to meet general expenditures within one year	$10,511,486	$ 9,988,730

The Organization's goal is generally to have, at the minimum, the Health Resources and Services Administration recommended days cash on hand for operations of 30 days and 90 days cash in reserve. Average days cash on hand was higher than the Organization's goal due to various COVID-19 related relief payments disclosed in Note 1.

The Organization has an available $500,000 line of credit as described in Note 5.

3. Investments

FASB ASC Topic 820, *Fair Value Measurement*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in an orderly transaction between market participants and also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The fair value hierarchy within FASB ASC Topic 820 distinguishes three levels of inputs that may be utilized when measuring fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The following table sets forth by level, within the fair value hierarchy, the Organization's investments at fair value measured on a recurring basis:

	Investments at Fair Value as of June 30, 2021			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 38,545	$ -	$ -	$ 38,545
Corporate bonds	-	498,192	-	498,192
Government securities	-	282,813	-	282,813
Total investments	$ 38,545	$ 781,005	$ -	$ 819,550

	Investments at Fair Value as of June 29, 2020			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 77,926	$ -	$ -	$ 77,926
Corporate bonds	-	400,116	-	400,116
Government securities	-	339,754	-	339,754
Total investments	$ 77,926	$ 739,870	$ -	$ 817,796

Corporate bonds and government securities are valued based on quoted market prices of similar assets.

4. Property and Equipment

Property and equipment consists of the following:

	2021	2020
Land and improvements	$ 153,257	$ 153,257
Building and improvements	3,395,226	3,308,100
Furniture, fixtures, and equipment	2,410,500	2,402,307
Total cost	5,958,983	5,863,664
Less accumulated depreciation	3,818,573	3,555,696
Property and equipment, net	$ 2,140,410	$ 2,307,968

Property and equipment acquired with Federal grant funds are subject to specific federal standards for sales and other dispositions. In many cases, the Federal government retains a residual ownership interest in the assets, requiring prior approval and restrictions on disposition.

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Notes to Financial Statements

June 30, 2021 and 2020

5. Line of Credit

The Organization has a $500,000 line of credit with a local bank, which renews annually in December. The line of credit is collateralized by the Organization's business assets with interest at the prime rate plus 1.50% (4.75% at June 30, 2021). There was no outstanding balance at June 30, 2021 and 2020.

6. Net Assets

Net assets were as follows as of June 30:

	2021	2020
Net assets without donor restrictions		
Undesignated	$ 8,917,110	$ 6,490,314
Designated for working capital	1,971,084	2,243,888
Total	$ 10,888,194	$ 8,734,202
Net assets with donor restrictions for specific purpose		
Healthcare services - temporary in nature	$ 65,352	$ 77,723
Endowment - permanent in nature	26,083	26,083
Total	$ 91,435	$ 103,806

7. Patient Service Revenue

Patient service revenue by payer is as follows:

	2021	2020
Governmental payers:		
Medicare	$ 2,549,705	$ 2,566,782
Medicaid	1,965,933	2,143,676
Commercial payers:		
Anthem Blue Cross Blue Shield	988,605	1,001,188
Other commercial payers	1,716,971	1,796,450
Patient	305,027	608,757
Total direct patient service revenue	7,526,241	8,116,853
Provision for bad debts	-	(353,736)
Net direct patient service revenue	7,526,241	7,763,117
340B contract pharmacy revenue	2,748,442	2,984,563
Net patient service revenue	$ 10,274,683	$ 10,747,680

8. Malpractice Insurance

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of the year ended June 30, 2021, there were no known malpractice claims outstanding which in the opinion of management, will be settled for amounts in excess of both FTCA and additional medical malpractice insurance coverage; nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew the additional medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

9. Benefit Plans

The Organization has a defined contribution plan under Internal Revenue Code Section 401(k) that cover substantially all employees. The Organization contributed $276,429 and $257,796 for the years ended June 30, 2021 and 2020, respectively.

The Organization provides health insurance to its employees through a self-insurance plan with a re-insurance arrangement to limit exposure. The Organization estimates and records a liability for claims incurred but not reported for employee health provided through the self-insured plan. The liability is estimated based on prior claims experience and the expected time period from the date such claims are incurred to the date the related claims are submitted and paid.

10. Lease Commitments

The Organization leases office space and certain other office equipment under noncancelable operating leases. Future minimum lease payments under these leases are:

2022	$ 96,788
2023	108,402
2024	57,270
Total	$ 262,460

Rent expense amounted to $177,376 and $124,760 for the years ended June 30, 2021 and 2020, respectively.

COOS COUNTY FAMILY HEALTH SERVICES, INC.
54 WILLOW STREET – BERLIN, NH 03570
752-3669
BOARD OF DIRECTORS

Patti Stolte, 2023 (2nd)
****PRESIDENT****
Chair, Executive Committee
Chair, Personnel Committee
Executive Director, Family Resource Center

Kassie Eafrati, 2022 (1st)
****VICE-PRESIDENT****
Director of Behavioral Health /Northern Human Services

Magen Moreau
****TREASURER****
Financial Services, Northeast Credit Union 362 Church Street

Pauline Tibbetts, 2023 (2nd)
****SECRETARY****
Retired Nurse, Respite Caregiver & Hospice Volunteer

H. Guyford Stever, Jr., 2022 (4th)
****IMMEDIATE PAST PRESIDENT****
Retired English Teacher
Executive Committee

Robert Pelchat, 2023 (7th)
Retired Electronics Engineer

Marge McClellan, 2023 (7th)
Retired Executive Director – AV Home Care

Roland Olivier, 2023 (3rd)
Attorney
Chair, Health Care Reform Committee

David Morin, 2023 (3rd)
Retired Berlin Merchant – Morin Shoe Store
Chair, Governance Committee

Claudette Morneau, 2023 (2nd)
Retired RN
Chair, Quality Improvement Committee

Cynthia Desmond, 2022 (1st)
Retired Pharmacist
Chair, Corporate Compliance Committee

Gregg Marrer, 2023 (1st)
Office Manager

Alana Scannell, 2023 (1st)
School Social Worker

Rebecca Witmon, 2024 (1st)
Attorney

Holly Carter, 2024 (1st)
Police Officer

Bonnie de Vries, MD MS (she, her, hers)

[redacted]

SUMMARY

I am a Board-certified Family Medicine physician with a passion for population health and a diverse background in healthcare administration. Areas of expertise include innovation and quality improvement through the creation of multidisciplinary teams and the development of a culture of collaboration, communication, and accountability.

SELECTED PROFESSIONAL EXPERIENCE

Medical Director at Washington State University, Pullman, WA (4/2018-current)

I direct all aspects of medical care at this Division 1 university campus of 21,000 students, whose student health center was recently ranked among the nation's top 10 by Princeton Review. I have lead compliance, risk management, public health planning, professional development, and quality improvement for all departments at Cougar Health Services. I supervise staff within the medical clinic, vision clinic, EMR team, and billing. I collaborate with multiple departments across the university, including the Dean of Students, Athletics, University Recreation, University Police, Environmental Health and Safety, the Office of the Attorney General, and the College of Medicine. For the entire WSU system of 6 campuses and 39 extensions, I provide medical advisement and oversee nurse phone coverage. I partner with the local hospital and law enforcement on community health and resources. I serve on the Faculty Senate Budget Committee and serve many other responsibilities.

Practice Improvement Coordinator for The Advanced Primary Care Project at Southern Maine Health Care (SMHC) Saco Family Medicine, Saco, ME (1/2015–12/2016)

At the request of the Senior Vice President, I coordinated this joint venture between SMHC and MaineHealth to innovate primary care solutions that could advance our clinics toward the industry-standard Quadruple Aim in an Accountable Care Organization (ACO) environment. Our primary focus was to improve population health through team-based care. Toward this aim, I developed a structured approach that identified and addressed existing barriers to improvement and engagement; I created an innovation model for population health; and I worked with senior leadership to support sustainable change through careful metrics, methods of provider accountability, and an updated physician compensation plan.

Family Doctor at SMHC Saco Family Medicine, Saco, ME (9/2012–1/2017)

I provided excellent care for the patients of this medical clinic, designated a Level 3 Patient Centered Medical Home. My patients ranged from newborns to the very elderly, and included members of Maine's numerous immigrant groups, as well as the homeless population. I wrote the handbook for new providers entering the practice. I also represented physicians as part of a Transitions Team that oversaw the merger of two clinics.

Medical Executive Committee member at-large at SMHC (1/2015–12/2016)

I was elected by the medical staff to serve on this 9-member committee that governed the hundreds of doctors on the staff of Southern Maine Health Care (SMHC). The Medical Executive Committee was responsible for physician appointing, privileging, and disciplinary actions. We reported directly to the CEO on these matters.

Bonnie de Vries, MD MS (she, her, hers)

[redacted]

Assistant Clinical Professor of Medicine at the University of New England, Biddeford, ME (9/2012–12/2015)

I taught second-year medical students about team development, diagnosis, case presentation, and point of care research methods through a case-based curriculum.

EDUCATION

Hanley Center for Health Leadership's Physician Executive Leadership Institute, 2016

I was personally selected to attend this certificate program by the leadership of Southern Maine Health Care. Hanley's PELI program trained me in change management, healthcare finance, medical personnel management, emerging healthcare trends, and more.

Maine Medical Center, Family Medicine Residency, 2012

During residency, I served on MMC's FM-Team committee, which set the direction for the Family Medicine Department. I performed a pre-visit planning quality improvement project and lectured residents and faculty about asthma management, cholesterol screening in children, and patient safety and quality, among other topics.

University of Arizona, 2012

I earned a Certificate in Integrative Medicine.

Albany Medical College, MD, 2009

Columbia University, MS in Nutrition, 2003

I trained in public health, biostatistics, and scientific research. As part of this program, I was a Clinical Research Assistant at Harlem Hospital in New York City, and managed one branch of a multinational study of HIV-related lipodystrophy among the underserved African American community in Harlem. I also wrote several proposals for NIH and other grant sources; assisted the MetLife corporate offices in downtown Manhattan with developing their online employee health materials; and designed a layperson-oriented educational web site about managing diabetes.

Houghton College, BS in Biology, 1998

I was the first person in my family to attend college.

PROFESSIONAL AFFILIATIONS

American Academy of Family Physicians
Washington State Medical Association
Medical Group Management Association
American College of Healthcare Executives
American College Health Association
Pacific Coast College Health Association

VALERIE HAMEL

[redacted]

I am seeking to utilize well-developed leadership, teaching, strategic thinking and communication skills in order to promote patient focused care and to optimize the health and well-being of vulnerable populations.

EXPERIENCE

Nurse Manager Coos County Family Health Services – Berlin NH
June 2020 – Present
Responsible for the oversight and management of the nursing department at a Community Health Center encompassing three sites. Supervisor to 44 employees. Assists and fills in for the COO when needed. Assisted the COO to create and implement a Covid-19 testing clinic. Currently assisting a community partner, AVH, to implement a Covid-19 Vaccine clinic. Regularly gathers data, performs data analysis, and prepares QI reports. Address employee issues, patient complaints, and completes audits to ensure appropriate and timely patient care.

Director of Nursing Services Marshwood Center - Lewiston, ME
April 2019 to June 2020
Responsible for the oversight and management of a 108 bed nursing facility. Supervisor to 80 employees. Served as the Infection Control Specialist, the facility certified wound care nurse, and the QAPI team leader. Implemented Advantage Wound Care Services to improve wound outcomes.

Staff Development Coordinator Catholic Charities St. Vincent du Paul Nursing Center
October 2018 to April 2019
Responsible for education development, implementation, and tracking for 90 employees. Also managed the wound care program as the only wound certified nurse at the facility. Became certified in infection control and served as the Infection Control Specialist.

Director of Nursing Services Maine Veterans Homes – South Paris ME
November 2015 to September 2018
Responsible for oversight and management of the nursing department for a five star nursing facility which included supervision of approximately 100 employees. Responsible for care and management of 62 dually certified long term care beds. Corporate Design Team Lead for the continuing development and implementation of the electronic medical records system. Responsible for Performance Improvement and a member of the QAPI committee. Member of the Corporate Staff Stability Committee. Implemented Telepsyche services to improve Antipsychotic Rates. Implemented a Falls Committee to improve resident fall rates to best practice levels. Implemented a Readmissions Committee to reduce hospital readmissions. Implemented in house wound care services and eye care services. Co-wrote a winning Baldrige Silver application with four other department heads and the administrator.
Per Diem Clinic Nurse Bethel Health Center – Bethel ME

October 2010 – April 2020
Clinic nurse responsible for patient assessment, gathering a variety of lab specimens, and administering medications and treatments as ordered by the medical provider. Rooming and preparing patients for provider visits, accurate and timely documentation.

Staff Development Coordinator Maine Veterans Homes – South Paris, ME
September 2013 to October 2015
Responsible for development, implementation, and tracking of education for all facility staff, approximately 150 staff members. Also responsible for development, implementation and oversight of the facility Infection Control Program and also management of the Workers Compensation Program. Implemented the Relias online education system and also educated and assisted with implementation of the American Data electronic medical records system. Certified in Wound Care and provided hands on care, assessment and consultation to medical providers for residents with wounds

Daytime RN Charge Nurse Maine Veterans Homes – South Paris, ME
2008 to 2013
Responsible for 32 dually certified beds in the nursing facility/ skilled unit. Direct supervisor to 4 employees that included education about patient care, clinical tasks, procedures and equipment use. Active member of the Wound Committee with responsibilities that include compiling weekly data about wounds in the facility and educating staff members about wound documentation, treatment, and prevention.

Nighttime Supervisor Rumford Community Home - Rumford, ME
July 2006 to January 2007
Direct supervisor to 5 employees, responsible for the efficient operation of the entire facility for the duration of the night shift.

RN Staff Nurse Rumford Hospital - Rumford, ME
May 2006 to July 2006
Med Surg Unit nursing responsible for supervision and delegation to CNAs, performed direct patient care and administered medications and treatments as ordered by the medical staff.

Private Duty Nurse – Bethel, ME
2005 to 2006
-Private nursing duties for 5 customers. Serviced clients of all ages and was responsible for medication administration and direct care.

Business Co-Owner Baywood Builders - Augusta, ME
1995 to 2005
Provided residential contracting for private homes. Responsibilities included payroll, bookkeeping and tax preparation, OSHA safety compliance, warehouse management and inventory, assisting with sales, scheduling and supervising subcontractors, arranging for code inspections and obtaining building permits.

EDUCATION

Certification in Wound Care
Wound Education Institute - Portland, ME 2014
BSN in Nursing
University of Maine Fort Kent - Fort Kent, ME 2012
BA in Psychology
University of Southern Maine - Portland, ME 2008
AD in Nursing
White Mountain Community College – Berlin NH 2002
Certification in Field Medic Emergency Medicine
United States Academy of Medicine Fort Sam Houston Antonio TX - San Antonio, TX 1993
High school
Monmouth Academy - Monmouth, ME 1990

AWARDS

Coos County Family Health Services
Newbie of the Year 2020
Covid Crusader 2020

Maine Veterans Homes
Employee Wellness Award 2018
Employee of the Month Jan 2014
Employee of the Month September 2008

CINDY CHAREST

PROFESSIONAL SUMMARY

Skilled team player, but also works well independently to handle assignments. Always ready to go beyond basics assignments. Quick learner with good computer abilities.
Hardworking nurse focused on completing quality work quickly to consistently exceed targets. Reliable team member accustomed to taking on challenging tasks. Dedicated to business success.

SKILLS

Coordination	Teamwork	Organization
Collaboration	Problem-solving	Training and development
Process improvement	Detail Oriented	

EXPERIENCE

CCFHS Berlin, NH
Care Management, July 2016 – current

- Maintained compliance with established policies, procedures, regulatory and accreditation requirements, and applicable professional standards.
- Kept anxious patients calm by explaining upcoming procedures and answering questions.
- Triaged, took messages, and followed-up to verify receipt of important information.
- Interacted with insurance companies for incentive programs and to encourage patient engagement in closing gaps of care.
- Completed and processed insurance documentation and other claim forms.
- Scheduled patient exams around availability of physician.
- Reviewed patient charts for completeness and accuracy and verified missing information.
- Used Excel and insurance portals regularly to compile records, produce reports.
- Safeguarded confidentiality of patient information by consistently following patient protection standards.
- Delivered excellent customer service and facilitated development of patient and clinician relationships.
- Updated patient record with all admission, transfer, and discharge information.
- Delivered an excellent service experience with friendly, compassionate, and helpful demeanor.

MEMORIAL HOSPITAL North Conway, NH
Clinical Nursing Coordinator, September 2015 – June 2016

- Managed schedules, overtime, and coverage for staff.
- Assessed, monitored, and educated nursing staff on patient care.
- Worked collaboratively with patients, physicians, and staff to support patients and families through resolution.
- Directed, supervised, and evaluated work activities of nursing personnel.
- Interviewed, hired, and oriented staff and managed ongoing staff development initiatives.
- Helped to develop/implement new Care Management program.
- Kept staff trained and up-to-date with CLIA testing.

MEMORIAL HOSPITAL North Conway, NH
Primary Care Nurse October 2013 – September 2015

- Handled routine medication refills and set up appointments for scheduled assessments in place of automatic renewals.
- Presented health education materials to encourage healthy choices and proper self-management.
- Assisted primary care providers with developing individualized, integrated care plans.
- Helped front desk personnel answer patients' medical, clinical, and operational questions.
- Triaged calls from established patients to determine and prioritize care responses.
- Coordinated daily patient flow between waiting rooms, intake, and treatment rooms.
- Recorded patients' medical information and monitored conditions.
- Kept the unit efficient by organizing instruments, preparing rooms and restocking supplies.
- Recorded patients' medical information and vital signs.
- Prepared patients for physician examinations and treatments, answered questions and offered emotional support.
- Immunized patients against common infections such as influenza and tetanus with routine vaccinations.

CCNH Berlin, NH
Charge RN, June 2011 – October 2013

- Charted pertinent facts and information in detail.
- Evaluated patient response to nursing interventions and altered care plans through ongoing assessments.
- Admitted patients according to policy.
- Transferred and repositioned patients using proper techniques and equipment.
- Directed resident care and helped patients with personal grooming.
- Visited all assigned patients at regular intervals, checking and documenting vital signs and patient conditions.
- Utilized nursing process in provision of care, including medication administration and treatments.
- Trained as back up supervisor - documented nurses' notes, doctors' orders, discharge plans, dietary changes, reports, evaluations, studies, in charts; supervised nursing department in daily delivery of resident care.

CCNH Berlin, NH
Charge LPN, May 2010 – June 2011

- Same responsibilities as Charge RN, only not able to pronounce death of patient.

CCNH Berlin, NH
LNA, January 2008 – May 2010

- Assisted with meals, bathing, toileting, dressing, and grooming.
- Adhered to resident care standards and practices to maintain quality care.
- Communicated with residents and families to provide care updates and information.
- Assisted with range of motion exercises to maintain mobility.
- Ensured complete documentation when entering data into the EMR system.
- Responded immediately to calls from patients for assistance or treatment and alerted medical staff to emergency situations.

CCNH Berlin, NH
Dietary Aide, January 2003 – January 2008

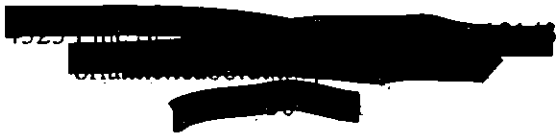
EDUCATION

Associate of Science, RN — May 2011
WMCC – Berlin, NH

REFERENCES

Jamie Arsenault	co-worker	[redacted]
Erica Dyer	former co-worker	
Angela Clark	co-worker	

Brianne Teaboldt, MD
University of Pennsylvania Family Medicine Residency Program, Class of 2018



Education

2015-2018 University of Pennsylvania Family Medicine Residency
Expected graduation August 2018

2011-2015 University of Maryland School of Medicine
M.D., May 2015

2007-2008 Goucher College
Premedical Post-baccalaureate Certification

1999-2003 Smith College
B.A. in Psychology, *magna cum laude*

Oxford University
Visiting student, 2001-2002

Membership in Honorary Societies

2003–Present Phi Beta Kappa

Certification

2017-present American Red Cross, BLS certified
2015-2017 American Red Cross, ACLS certified

Research and Work Experience

2017-2018 University of Pennsylvania Family Medicine Residency – *Quality improvement research*
Longitudinal project aimed at improving patient satisfaction with after-hours triage line. Implementing A3 style research approach to systematically target call center infrastructure and on-call triage model to reduce return-call time and improve response efficiency and perceived resolution.

2009-2011 University of Maryland School of Medicine - *Research Assistant*

Investigated gene pathway and micro-RNA interaction by performing leukemia cancer cell transfections, Luciferase Reporter assays, Western Blot assays, protein purification procedures, and qRT-PCR reaction assays. Specific research focus: mRNA-23a cluster interaction with 14-3-3 protein isoforms in Chronic Myelogenous Leukemia.

2008-2009 Johns Hopkins Medical Institute – *Research Technologist*
Applied cell culture, recombinant DNA, PCR, and protein expression techniques to hematopoietic stem cell research; Managed lab inventory; Ordered general and special laboratory equipment; Assisted post-doctoral fellows and graduate students in ongoing microRNA research projects.

Publications

Scheibner KA, **Teaboldt B**, Hauer MC, Chen X, Cherukuri S, Guo Y, Kelley SM, Liu Z, Baer MR, Heimfeld S, Civin CI. "MiR-27a Functions as a Tumor Suppressor in Acute Leukemia by Regulating 14-3-3θ" PLOS One. 2012 Dec 7; 7(12): e50895.

Poster Presentations

Cocchiaro, B, Wang J, **Teaboldt B**, Bogner H, Cronholm P, McClintock, H. "Depression Screening and Management in the Patient Centered Medical Home: Provider and Staff Perceptions of Facilitators and Barriers", North American Primary Care Research Group Annual Meeting, Montreal, Quebec, November 2017.

Scheibner, KA, **Teaboldt B**, Kelley, SM, Hauer, MC, Chen, X, Cherukuri, S, Guo, Y, Liu, Z, Baer, MR, Heimfeld, S, and Civin, CI. "Mir-27a and other mir-23a cluster members effect cell growth by regulating multiple members of the wnt pathway", Maryland Stem Cell Research Foundation Annual Symposium, Towson, MD, October 2011.

Scheibner KA, **Teaboldt, B**, Hauer, MC, and Civin CI "The Mir-23a~Mir-27a~Mir-24 Cluster Acts as a Tumor Suppressor In Leukemias by Post-Transcriptional Regulation of 14-3-3 Proteins", American Society of Hematology annual meeting, Orlando, FL, December 2010.

Additional Work Experience

2008–2015 Charm City Yoga, Baltimore, MD – *Certified Yoga Instructor*
Lupin Pharmaceuticals, Inc., Baltimore, MD

2006–2007 Fresh Yoga, New Haven, CT– *Certified Yoga Instructor*
West Hartford Yoga, West Hartford, CT

2006–2007 Self-employed, West Hartford, CT – *Private Algebra Tutor*

2005–2006 Ice skating training product LLC, New Haven, CT – *Manager*

2003-2007 Champions Skating Center, Cromwell, CT – *Professional Figure Skating Instructor*
Yale University, New Haven, CT
Louisville Skating Academy, Louisville, KY

2003–2004 Artemesia Restaurant, Louisville, KY – *Server*

2002–2003 Smith College Career Development Office, Northampton, MA – *Administrative Assistant*

2000-2001 Smith College Residence & Dining Services, Northampton, MA – *Work study Coordinator*

Volunteer and Leadership Experience

2015-present UPenn Family Medicine Residency Wellness Group – *volunteer yoga instructor*

2014 Habitat For Humanity, Baltimore, MD – *On-site building volunteer*

2012–2013 Medical Students For Choice, Univ. of MD School of Medicine - *President*
Women's Health Interest Group, Univ. of MD School of Medicine – *Co-president*
American Medical Students Association, Univ. of MD School of Medicine – *Co-leader*

2011–2012 Center for Livable Futures, Baltimore, MD – *Service Learning Community Outreach*

2009–2012 Shepherd's Clinic, Baltimore, MD – *Volunteer Yoga Instructor*

2007–2008 Johns Hopkins Bayview Hospital, Baltimore, MD – *Patient Representative*
Served as liaison between Emergency Department patients and hospital administration; Communicated with patients and report concerns, comments and complaints; Assisted staff with general patient care.

2006–2007 The Rosie Fund, Inc., Hamden, CT – *Patient Relations Coordinator*
Served as liaison to health clinics for girls and women seeking abortion services; Interviewed and counseled callers to assess their circumstances and determine their need for financial assistance.

2005–2007 Planned Parenthood, New Haven, CT – *Medical Staff Assistant*
Assisted in health clinic recovery room, taking vitals and aiding and educating patients; Assisted physician and staff in surgery; Participated in awareness-raising and educational activities outside clinic setting.

2005–2006 NARAL Pro-Choice Connecticut, Hartford, CT – *Outreach Coordinator*
Attended regular bi-monthly meetings to discuss and plan awareness-raising and educational events; Researched statewide pharmacy practices for Emergency Contraception research project.

Membership in Professional Societies

2013–Present	American Academy of Family Medicine
2011–Present	American Medical Association
2006–2015	Yoga Alliance
2003-2007	Professional Skaters Association

Accomplishments

1994-2003	US Figure Skating Gold Level Achievements – Pairs, Ice Dancing, Moves in the Field
1994	US National Novice Pairs Skating Champion, 1994 U.S. Figure Skating Championships
1993	US Junior National Ice Dance Bronze Medalist, 1993 Junior National Skating Championships

JANET L. CHEVARIE, OB-GYN A.R.N.P.

[redacted]

EDUCATION/CLINICAL	Coos County Family Health Services 54 Willow St. Berlin, N.H. OB-GYN clinics under supervision of Normand Couture, M.D. Donald Kernan, M.D. Sherrill Tracy, M.D. Barbara Kolinsky, P.A. July 1984-July 1985
	University of Penn. School of Nsg. Center for Continuing Education Philadelphia, PA Spring session 1984 Certificate, OB-GYN Nurse Practitioner
	Sacred Heart Hospital School of Nsg. Manchester, N.H. 1968-1971 Diploma in Nursing
HONORS/AWARDS	Sr.M.Virginia Award for Scholastic Excellence 1971 Nurse of the Year Award 1985
EMPLOYMENT/ ACTIVITIES	Coos County Family Health Services Berlin, N.H. Multi-program medical/ social agency providing services to mainly low income population 1980 to present
	Androscoggin Valley Hospital Berlin, N.H. OR/Recovery Unit Intensive Care Unit 1975-1980
	University of Vermont Medical Center Burlington, VT Intensive Care Unit 1973-1974
	Boulder Community Hospital Boulder, CO Medical-Surgical Unit 1971-1973
54	Taught Women's Health Issues course for University Systems of N.H. School for Lifelong Learning

Spring 1985 & 1989

Founding member of Concerned Citizens for Education/spear-headed campaign to change city charter re. election of school board members 1993

Involved in task force to obtain ODAP grant in order to have in-house substance abuse counselor available for prenatal clients 1993-94

Member of Provider Recruitment & Retention Committee at CCFHS 1993 to present

PROFESSIONAL ASSOCIATIONS

New Hampshire Nurse Practitioners Assc.

PERSONAL

Date of Birth 12/14/50
Married two children
Leisure interests: Downhill, XC skiing, gardening, outdoor activities, reading

REFERENCES

See application

Bridget Laflamme

[redacted]

PROFESSIONAL EXPERIENCE

Coos County Family Health Services
11/6/03 - Present Community Health Educator
RESPONSE to Sexual and Domestic Violence, Berlin NH: Education and Volunteer Coordinator (2002- 11/5/03

- Responsible for recruitment, training and support of volunteers
- Schedule volunteer and staff on-call time for crisis line
- Provide community, professional, and school presentations
- Provide direct services to survivors of sexual and/or domestic violence

RESPONSE to Sexual and Domestic Violence, Lancaster, NH: Direct Service Advocate (10/2000 to 2002)

- Responsible for providing direct services to survivors of sexual and/or domestic violence including crisis intervention and court advocacy.
- Prepared and facilitated weekly support groups.
- Developed local resources for clients including police, legal and judicial professionals, and social services.

RESPONSE to Sexual and Domestic Violence, Berlin, NH: Domestic Violence Program Specialist (3/1999 to 10/2000)

- Provided education on domestic violence issues to professionals who work with victims. Professionals included: medical personnel, police departments, school personnel, court and legal personnel, and local social service agencies.
- Enhanced services to domestic violence victims and their families by providing outreach to victims, increasing public awareness of domestic violence issues, and networking with area agencies.
- Spent 20 hours a week working with Division for Children, Youth and Families caseworkers and clients providing case consultation, referrals, support, education, training and overall skills building.

NFI Davenport School, Jefferson, NH: Residential Supervisor (4/1998 to 12/1998)

- Provided weekly supervision to six counselors.
- Supervised youths ages 13-17 in all aspects of their daily schedules, including socialization skills, academic, community and group skills.

NFI Davenport School, Jefferson, NH: Counselor (07/1995 to 04/1998)

- Supervised and instructed youths ages 13-17 on socialization, academic, community and group skills and personal hygiene.
- Utilized counseling skills to facilitate understanding between youths, and encourage stronger self-image of each.
- Encouraged youth to become more responsible for him/herself and to others.
- Developed an effective rapport with each student through activities and conversation in an effort to understand his/her behavior, attitudes, needs, and problems.

Division of Children, Youth and Families, Conway, NH: Child Protective Intern (10/1994 to 05/1995)

- Worked with the State of New Hampshire Child Protection Workers investigating child abuse and neglect.

EDUCATION: Bachelor of Science Human Services-Counseling, Lyndon State College.

Philip G. Kneer Jr.

[redacted]

Presented by: 330 TALENT

Education: **Bachelor of Business Administration in Accounting**
Dowling College, Oakdale, New York
Dean's List
G.P.A. 3.7

Professional Experience:

Indian Stream Health Center **Colebrook, NH**
A rural Federally Qualified Health Center (FQHC) with 58 employees and $6 million in annual revenue
Controller March 2017 – Present

- Responsible for all day to day accounting activities, preparation of financial statements and overseeing Accounts Payable and Payroll with one direct report.
- Update the daily cash position for the CFO & CEO.
- Perform and oversee month-end closing activities.
- Prepare and enter all General Ledger entries for the monthly close.
- Reconcile all Balance Sheet accounts.
- Prepare and analyze monthly financial statements and identify any aberrations.
- Provide all data to assist the CFO in preparing two annual budgets (Board of Directors & HRSA).
- Backup for biweekly payroll.
- Prepare monthly financial statements for the Board of Directors.
- Prepare and file Quarterly and Annual FFR Reports for HRSA.
- Implemented a new accounting and finance system, mapped all legacy general ledger accounts from QuickBooks Enterprise to Sage/Intacct.
- Point of contact for all annual insurance renewals.
- Point of contact for the annual audit.

Oak Tree Medical, P.C. **Greenville, SC**
Medical group consisting of 10 Pain Management Clinics
Interim Controller December 2015 – April 2016

- Oversee Accounts Payable Department with two direct reports.
- Manage day-to-day financial operations of a multi-location medical facility.
- Prepare weekly-anticipated cash reports for the CFO.
- Perform monthly closing.
- Prepare monthly financial reports.
- Work closely with corporate CPA firm on annual audit.

Sunrise Medical Laboratories, Inc. **Hicksville, NY**
A full-service clinical and anatomical pathology laboratory serving Maryland, New Jersey, New York, Virginia, Washington DC, and West Virginia with 500 employees and $100 million in annual revenue
Controller September 2001 – September 2015
Assistant Controller September 1999 – September 2001

- Responsible for four direct reports (Assistant Controller, two A/P Clerks & one Payroll Clerk).
- Comprised all necessary documentation for due diligence reporting in the acquisition of Sunrise Medical Laboratories by Sonic Healthcare USA.
- Mapped all legacy general ledger accounts from Sunrise Medical Antrim/Mysis system to Microsoft Great Plains.

- Lead contact for Sonic Healthcare with legacy system integration into Great Plains.
- Prepared all monthly uploads from the Sunrise legacy Antrim system into Great Plains.
- Worked directly with the VP of Sales calculating and preparing the monthly sales bonuses and commissions.
- Prepared and filed annual New York State Department of Health Revenue Reporting.
- Point of contact for all annual insurance renewals including professional liability insurance.
- Responsible for preparing the six-month and annual reporting packages for the Sonic Healthcare home office in Austin Texas.
- Team member in the acquisition of additional laboratories in Virginia, Rhode Island and Florida.
- Manage all aspects of the day-to-day financial operations of a multi-million dollar full service diagnostic medical laboratory.
- Prepare midyear and annual group reporting packages.
- Prepare monthly balance sheet reconciliations.
- Perform monthly closing.
- Prepare monthly financial reports.
- Prepare monthly New York State & Virginia Sales & Use Tax Returns.
- Prepare quarterly New York State Hazardous Waste Returns.
- Prepare annual budgets.
- Activate all new client accounts and approve all special pricing.
- Approve and print all accounts payable checks.

Bedell and Company CPAs (owner of Advanced Payroll Systems, Inc.) **Stony Brook, NY**
A CPA firm providing accounting, tax, payroll and financial management solutions to individuals and small businesses
Accountant July 1997 – September 1999

- Managed twenty-eight client accounts, mainly small businesses (Landscapers, Photographers, Exterminators, etc.).
- Prepare monthly bank reconciliations (Manually and on Quicken).
- Prepare monthly client write-ups.
- Analyze and code monthly client information.
- Prepare quarterly payroll tax returns.
- Prepare quarterly sales tax returns.
- Perform year-end closings.
- Input and print various tax forms.
- Answer various client correspondence (IRS and NYS tax notices).
- Trained new employees.
- Developed excellent client relation skills.
- Performed corporate year-end adjustments and closings.
- Prepare corporate tax returns.
- Manage and coordinate all phases of Advanced Payroll Systems Inc.

Skills: Microsoft Great Plains, Antrim/Mysis Financial System, Microsoft Excel, Microsoft Word, Microsoft FRx, QuickBooks Enterprise, Sage/Intacct

Kenneth E. Gordon

[redacted] [redacted]

WORK EXPERIENCE

CHIEF EXECUTIVE OFFICER: Coos County Family Health Services, Berlin, New Hampshire (2/15 – present)

- Provided administrative and strategic leadership to a Federally Qualified Health Center serving approximately 12,000 patients.
- Work closely with the organization's Board of Directors to establish policy and to monitor performance in the realms of finance, clinical quality, consumer and staff satisfaction.

ADMINISTRATOR: North Country Health Consortium, Littleton, New Hampshire (8/13 – 2/15)

- Provide administrative leadership of the North Country Accountable Care Organization, a newly formed non-profit entity comprised of four community health centers working in collaboration to improve the health and well-being of North Country residents.

EXECUTIVE DIRECTOR: Area Agency on Aging for Northeastern Vermont, St. Johnsbury, Vermont (9/02 – 7/13)

- Provided administrative leadership to a private, non-profit human service agency serving older adults and family caregivers.
- Financial management of the organization's budget.
- Supervision of clinical and administrative staff.

SOCIAL SERVICES COORDINATOR: Caledonia Home Health Care and Hospice, St Johnsbury, Vermont (8/97 - 8/02)

- Provided medical social work to individuals and families receiving home care and hospice services.
- Supervised and coordinated the work of four master's level staff members.
- Provided consultation to medical staff regarding psycho-social issues.
- Participated in discharge planning with other social service and health agencies.

CHILD PROTECTIVE SERVICE WORKER: Vermont Department of Social & Rehabilitation Services, St. Johnsbury, Vermont (5/96 - 8/97)

- Coordinated multidisciplinary treatment teams providing services to families.

- Psychosocial assessment & case planning.
- Care Management (Medicaid reimbursable).
- Individual and family counseling.
- Placement and supervision of children in foster care.
- Preparation of court reports.

ADOPTION SOCIAL WORKER: Vermont Department of Social & Rehabilitation Services, St. Johnsbury & Newport, Vermont (4/90 -9/94)

- Recruitment, training and assessment of adoptive applicants.
- Placement and supervision of abused and neglected children with adoptive families.
- Counseling with birth parents considering the voluntary relinquishment of a child.
- Consultation with casework staff regarding adoption issues.
- Preparation of adoption homes studies and probate court reports.

FOSTER CARE COORDINATOR: Vermont Department of Social & Rehabilitation Services, St. Johnsbury, Vermont (12/86 - 4/90)

- Managed a foster care program serving approximately fifty children.
- Fiscal administration, program planning and evaluation.
- Curriculum development and in-service training.

ASSISTANT DIRECTOR: Upward Bound Project, Lyndon State College (9/85 - 12/86)

- Co-directed a college preparatory program for disadvantaged youth.
- Formulated program goals and evaluated outcomes.
- Co-authored a successful federal grant proposal totaling more than $400.00.
- Training, supervision and evaluation of staff.
- Academic and career counseling.

EDUCATION

MASTERS OF SOCIAL WORK (M.S.W.) May 1996. University of Vermont

- 1st year field internship: Reach Up Program, Vermont Department of Social Welfare
- 2nd year clinical internship: Fletcher Allen Health Care, Inpatient Psychiatric Unit

BACHELOR OF SCIENCE (B.S.) Behavioral Science and Special Education. May, 1984. Lyndon State College, Lyndonville, Vermont

REFERENCES

Available upon request

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Key Personnel-SFY2022

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Ken Gordon	CEO	$174,200	0%	0
Valarie Hart	COO	$106,704	0%	0
Philip Kneer	CFO	$115,378	0%	0
Bonnie DeVries, MD	CMO	$247,998	0%	0
Cindy Charest, RN	CQO	$73,549	0%	0

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Key Personnel-SFY2023

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Ken Gordon	CEO	$174,200	0%	0
Valarie Hart	COO	$106,704	0%	0
Philip Kneer	CFO	$115,378	0%	0
Bonnie DeVries, MD	CMO	$247,998	0%	0
Cindy Charest, RN	CQO	$73,549	100%	$73,549

COOS COUNTY FAMILY HEALTH SERVICES, INC.

Key Personnel- SFY2024

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Ken Gordon	CEO	$174,200	0%	0
Valarie Hart	COO	$106,704	0%	0
Philip Kneer	CFO	$115,378	0%	0
Bonnie DeVries, MD	CMO	$247,998	0%	0
Cindy Charest, RN	CQO	$73,549	100%	$73,549

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-05)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Greater Seacoast Community Health		1.4 Contractor Address 311 Route 108 Somersworth, NH 03878	
1.5 Contractor Phone Number (603) 841-2350	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $1,232,685
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Janet Laatsch 487F1760DD2E79E0... Date: 5/17/2022		1.12 Name and Title of Contractor Signatory Janet Laatsch CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt D778B863F97D4C7... Date: 5/18/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino 74073484941400... On: 5/24/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials DS
Date 5/17/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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Date 5/17/2022

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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Date 5/17/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

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consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Increase Referrals to Home Visiting Programs for Qualifying Children, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Well Child Visits, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Breastfeeding, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any

period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.gov or mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Greater Seacoast Community Health*
Budget Request for:	*Primary Care*
Budget Period	*date of G&C - 6/30/22*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$40,738
2. Fringe Benefits	$8,569
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$49,307
Total Indirect Costs	$0
TOTAL	**$49,307.00**

Contractor Initials DS

Date 5/17/2022

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Greater Seacoast Community Health*
Budget Request for:	*Primary Care*
Budget Period	*SFY23*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$485,628
2. Fringe Benefits	$106,061
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$591,689
Total Indirect Costs	$0
TOTAL	**$591,689.00**

Contractor Initials DS

Date 5/17/2022

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Greater Seacoast Community Health*

Budget Request for: *Primary Care*

Budget Period *SFY24*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$485,628
2. Fringe Benefits	$106,061
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$591,689
Total Indirect Costs	$0
TOTAL	**$591,689.00**

Contractor Initials OS

Date 5/17/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

5/17/2022
Date

DocuSigned by:
Janet Laatsch
Name: Janet Laatsch
Title: CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract; continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/17/2022
Date

DocuSigned by:
Janet Laatsch
497E176D0257E0...
Name: Janet Laatsch
Title: CEO

DS
Vendor Initials JL
Date 5/17/2022

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

DS
Contractor Initials _____
5/17/2022
Date _____

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/17/2022
Date

DocuSigned by:
Janet Laatsch
487E1750D2E74E0...
Name: Janet Laatsch
Title: CEO

DS
Contractor Initials

5/17/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:
Janet Laatsch
48FF17CDD2E7420...

5/17/2022
Date

Name: Janet Laatsch
Title: CEO

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Janet Laatsch

5/17/2022
Date

Name: Janet Laatsch
Title: CEO

DS
JL
Contractor Initials

5/17/2022
Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Greater Seacoast Community Health
The State	Name of the Contractor
Signed by: Iain Watt D7788B63F0794G7...	DocuSigned by: Janet Laatsch 487F176DD2E74E6...
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Janet Laatsch
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	CEO
Title of Authorized Representative	Title of Authorized Representative
5/18/2022	5/17/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.

In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Janet Laatsch

5/17/2022
Date

Name: Janet Laatsch
Title: CEO

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 020304203

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening and Referrals for SDOH

Enabling Services Work Plan Agency Name: Greater Seacoast Community Health Name and Role of Person(s) Completing Work Plan: Jess Garlough, Director of Family and Social Services			
Enabling Services Focus Area: Social Determinates of Health Screening			
Project Goal: Assist clients in accessing additional supportive services and programs identified in SDOH screenings.			
Project Objective: Increase the number of patients 20 and over who are screened for SDOH when registered as a new patient. This will increase the screenings from 0% to 75% by August 2022.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each Activity)	Evaluation Plans (list as needed for each Activity)	Timeline for Activity (estimated timeline for the duration of each Activity)
Fill open social work position that will be part of the team responsible for screening social work intake form of New Patients (includes SDOH).	Human resources will complete posting and recruitment of full-time open position. Social Work Manager will be responsible for hiring and training new staff.	Social work manager will have weekly check-ins with the human resources recruiter on candidates and plan for recruitment efforts as needed.	Expected to fill and onboard position by May 2022
Create a new patient questionnaire with SDOH to screen patients for potential social service needs.	Social work team will work with the clinical team and front office staff to implement workflow where new patients are given screening tool.	Social Work Manager will audit at least ten new patient charts monthly to see if the screening tool is completed. The social work manager will report any lapses in screening to the front office manager for appropriate workflow adjustment, follow-up, and re-training as needed.	April 2022
Train social work staff to utilize the SDOH screening tool available in EMR (using.SDOH quick text) while seeing patients for non-urgent visits the first time.	Front office manager and patient experience manager will work together to create the most effective workflow for patient engagement and return rates.	Social Work Manager will audit social work visits to ensure this is completed. Appropriate follow-up as needed.	May 2022

Attachment #1 – Screening and Referrals for SDOH

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Social Determinates of Health Screening Project Objective: Increase the number of patients 20 and over who are screened for SDOH when registered as a new patient. This will increase the screenings from 0% to 75% by August of 2022.	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the Objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #1 – Screening and Referrals for SDOH

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	___Yes ___No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the Objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

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Attachment #1 – Screening and Referrals for SDOH

Work Plan Revisions submitted: ____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 – Increase Referrals to Home Visiting Programs for Qualifying Children

Enabling Services Work Plan
Agency Name: Greater Seacoast Community Health
Name and Role of Person(s) Completing Work Plan: Jess Garlough, Director of Family and Social Services

Enabling Services Focus Area: Increase the referrals for qualifying children to home visiting programs.

Project Goal: To increase families' connections in need of supportive services and early supports.

Project Objective: Increase the home visiting referrals for adolescents 21 and under made by GSCH. Agency will collect data from March 2022 through July 2022 to collect baseline data. Goal targets will be set in July 2022 going forward.

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each Activity)	Evaluation Plans (list as needed for each Activity)	Timeline for Activity (estimated timeline for the duration of each Activity)
Reach out to Strafford County Community Action Program (CAP) to confirm the most up-to-date referral process for client referrals.	Director of family and social services will outreach to the CAP family and child services director to coordinate.	Updated forms will be shared with social work, prenatal, and primary care teams. Education at staff meetings, primary care team meetings, and staff updates will be done to remind staff of the importance of referrals.	Outreach to CAP for updated materials – March 2022 Outreach to staff and continued education on referral process – April 2022
Update workflow for internal referrals to go through the social work department.	Director of family and social services will work with the social work manager to coordinate new internal workflow.	New workflow will be discussed at each monthly clinical staff meeting. Team social workers will discuss with their pods as well.	April 2022
Social worker team will update brochures and materials in clinical sites that offer benefits of home visiting programs.	Director of family and social services will outreach to local agencies for brochures and materials.	Materials will be distributed to CHOW worker and the social work team for distribution and display at sites.	April 2022
Internal workflow and integration of the family resource center's home visiting program will continue.	Director of family and social services will continue to work with the family center manager and staff to increase visibility and "warm hand-offs" to clients while in the center.	Increase integration of family center staff into clinical processes and departments, thus increasing referrals and expanded services.	April 2022

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Attachment #2 – Increase Referrals to Home Visiting Programs for Qualifying Children

Increase awareness with clinical staff and other programs that home visits can be referred from prenatal to age 21.	Director of family and social services, family center manager, and social work manager	Progress will be reviewed monthly via continuous quality improvement reports.	Monthly starting in April 2022

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Increase the referrals for qualifying children to home visiting programs. Project Objective: Increase the home visiting referrals for adolescents 21 and under made by GSCH. Agency will collect data March 2022 through July 2022 to collect baseline data. Goal targets will be set in July 2022 going forward.	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation	

Attachment #2 – Increase Referrals to Home Visiting Programs for Qualifying Children

plans or timeline? • Please give a brief update on your progress in meeting the Objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success.	

Attachment #2 – Increase Referrals to Home Visiting Programs for Qualifying Children

If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the Objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	

Attachment #2 – Increase Referrals to Home Visiting Programs for Qualifying Children

SFY24 Narrative: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 – Adolescent Well Child Visits

Quality Improvement Work Plan Agency Name: Greater Seacoast Community Health Name and Role of Person(s) Completing Work Plan: Megan Atkins, Data Analyst & Tonya Ames, Clinical Director			
MCH Performance Measure: Adolescent Well Child Visits- Percent of children ages 12 through 21 who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.			
Project Objective: Increase the number of adolescents with a well child visit within the last year from 58% (baseline January 2022) to 65% by January 2023 and 68% by January 2024.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each Activity)	Evaluation Plans (list as needed for each Activity)	Timeline for Activity (estimated timeline for the duration of each Activity)
Proactive annual reminder letters for WCC and immunizations	Administrative staff to send letters	Progress is to be reviewed monthly by the continuous quality improvement (CQI) Committee, CEO, clinical director, and board of directors	Ongoing
Letters for patients turning 18 years old offering support transitioning to adult care (including insurance assistance, social workers, etc.)	Administrative staff to send letters, social workers to help with obtaining resources, insurance assisters to help transition to adult insurance	Progress is to be reviewed monthly by the CQI Committee, CEO, clinical director, and board of directors	Ongoing
Utilize technology to send reminders (emails & text messages)	IT to set up email & text reminders system, administrative staff to upload reports into the reminder system	Progress is to be reviewed monthly by the CQI Committee, CEO, clinical director, and board of directors	Ongoing
Advertise and assist with obtaining insurance company patient incentives for completing yearly physicals	Marketing department to create advertising, administrative staff to help with paperwork required, insurance company provider representatives for materials	Progress is to be reviewed monthly by the CQI Committee, CEO, clinical director, and board of directors	Ongoing
Generate recall list using new scheduling system to ensure timely appointment scheduling	Administrative staff to enter recalls into the scheduling system and follow up on recall reports by	Progress is to be reviewed monthly by the CQI Committee, CEO, clinical director, and board	Ongoing

Attachment #4 – Adolescent Well Child Visits

	outreaching to patients	of directors Audits will be performed to ensure the recall list is accurate and beneficial.	
Prize drawing for adolescents who have their school physical prior to the start of the school year	Clinical management to obtain funding for a prize, administrative staff to assist with the drawing, marketing department to create advertising	Progress is to be reviewed monthly by the CQI Committee, CEO, clinical director, and board of directors	Summer-Fall 2022 and Summer-Fall 2023

QI Work Plan Progress Report Performance Measure: Percent of children ages 12 through 21 who had at least one comprehensive well care visit with a PCP or OB/GYN practitioner during the measurement year. Project Objective: Increase number of adolescents with a well child visit within the last year from 58% to 65% by January 2023 and to 68% by January 2024.	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted?	

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Attachment #4 – Adolescent Well Child Visits

• Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your	

Attachment #4 – Adolescent Well Child Visits

progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

Attachment #5 – Breastfeeding

Quality Improvement Work Plan Agency Name: Greater Seacoast Community Health Name and Role of Person(s) Completing Work Plan: Megan Atkins, Data Analyst & Tonya Ames, Clinical Director			
MCH Performance Measure: Breastfeeding- Percentage of infants ever breastfed or received breast milk who were born during the measurement year.			
Project Objective: Increase the number of infants who have received breast milk from 71% (baseline December 2021) to 77% by January 2023 and 80% by January 2024.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each Activity)	Evaluation Plans (list as needed for each Activity)	Timeline for Activity (estimated timeline for the duration of each Activity)
Start group zoom classes with lactation counselor for prenatal and postpartum patients	Certified lactation counselor to teach classes, IT for Zoom assistance, the marketing department for developing marketing materials and advertising on social media	Progress is to be reviewed monthly by the continuous quality improvement (CQI) Committee, CEO, director of family and social services, and board of directors	Start March 2022, then ongoing
New breastfeeding lounge in Portsmouth and Somersworth locations	Clinical management to request space, space utilization planning group to decide where to locate the lounges, social workers to promote lounges, WIC to promote lounges	Progress is to be reviewed monthly by the CQI Committee, CEO, director of family and social services, and board of directors A log will track the number of patients utilizing the rooms.	Start March 2022, then ongoing
Advertise breastfeeding lounges and Zoom classes across sites	Marketing department to create marketing materials and social media posts, prenatal and primary care staff to promote classes and lounge and hang marketing materials in exam rooms, social workers to promote classes and lounge, WIC to promote classes and lounge	Progress is to be reviewed monthly by the CQI Committee, CEO, director of family and social services, and board of directors	March 2022, then ongoing
Annual and as needed clinical	Clinical management to ensure	Progress is to be reviewed	Annually and as needed

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Attachment #5 – Breastfeeding

EMR documentation and metric training	yearly training, clinical staff to attend training, QI staff to develop a standardized training program	monthly by the CQI Committee, CEO, director of family and social services, and board of directors. Quarterly audits will be performed to identify documentation issues in the EMR.	
Add breastfeeding question to birth record QuickText for preloading of records	IT to add to QuickText, medical records to use QuickText for preloading old records, clinical staff to use QuickText for preloading of birth records	Progress is to be reviewed monthly by the CQI Committee, CEO, director of family and social services, and board of directors. Quarterly audits will be performed to identify documentation issues in the EMR.	February 2022, then ongoing
Partner with WIC to identify breastfed infants who are patients and enter data into EMR	Clinical management to partner with WIC, WIC to screen patients and report results of breastfeeding measure, medical records to preload results into EMR	Progress is to be reviewed monthly by the CQI Committee, CEO, director of family and social services, and board of directors	February 2022, then ongoing

QI Work Plan Progress Report Performance Measure: Percentage of infants ever breastfed or received breast milk who were born during the measurement year Project Objective: Increase number of infants who have received breast milk from 71% to 77% by January 2023 and to 80% by January 2024.	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline?	

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Attachment #5 – Breastfeeding

• Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year	

Attachment #5 – Breastfeeding

Work Plan Revisions submitted: _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your Objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

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Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. Breastfeeding

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. Preventive Health: Lead Testing

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2:2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

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Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

DS

5/17/2022

Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

DS

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

DS

5/17/2022

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS

5/17/2022

State of New Hampshire

Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that GREATER SEACOAST COMMUNITY HEALTH is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 18, 1971. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **65587**

Certificate Number: **0005744263**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of April A.D. 2022.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Dennis Veilleux, Vice Chair of Greater Seacoast Community Health, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of Greater Seacoast Community Health.

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on April 28, 2022, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Janet Laatsch

is duly authorized on behalf of Greater Seacoast Community Health to enter into contracts or agreements with the State
of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated:4/28/2022

Signature of Elected Officer
Name: Dennis Veilleux
Title: Vice Chair

GOODCOM-01 PCANTLIN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/11/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # AGR8150 Clark Insurance One Sundial Ave Suite 302N Manchester, NH 03103	CONTACT NAME: PHONE (A/C, No, Ext): (603) 622-2855 FAX (A/C, No): (603) 622-2854 E-MAIL ADDRESS: info@clarkinsurance.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Selective Insurance Co of South Carolina	19259
INSURED Greater Seacoast Community Health dba Goodwin Community Health, Families First SOS Community Organization, Lilac City Pediatrics 311 Route 108 Somersworth, NH 03878	INSURER B : Technology Insurance Company	42376
	INSURER C : AIX Specialty Insurance Co	12833
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR			S 2439491	12/1/2021	12/1/2022	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 500,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ Included
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY X SCHEDULED AUTOS			S 2439491	12/1/2021	12/1/2022	BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB X OCCUR						EACH OCCURRENCE	$ 1,000,000
	EXCESS LIAB CLAIMS-MADE			S 2439491	12/1/2021	12/1/2022	AGGREGATE	$ 1,000,000
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N	N / A		TWC4055247	1/1/2022	1/1/2023	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
C	Professional Liabili			L3V-A671986-07	1/1/2022	1/1/2023	Each Incident	1,000,000
C	Professional Liabili			L3V-A671986-07	1/1/2022	1/1/2023	Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Professional Liability excludes coverage for claims that are covered under the FTCA

CERTIFICATE HOLDER

State of New Hampshire
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
Margin Ruth

Greater Seacoast Community Health

Mission

"To deliver innovative, compassionate, integrated health services and support that are accessible to all in our community, regardless of ability to pay."

Board Approved on 6-25-2018

BerryDunn

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

FINANCIAL STATEMENTS

December 31, 2020 and 2019

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Greater Seacoast Community Health

We have audited the accompanying financial statements of Greater Seacoast Community Health, which comprise the balance sheets as of December 31, 2020 and 2019, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Greater Seacoast Community Health as of December 31, 2020 and 2019, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
July 15, 2021

GREATER SEACOAST COMMUNITY HEALTH

Balance Sheets

December 31, 2020 and 2019

ASSETS

	2020	2019
Current assets		
Cash and cash equivalents	$ 8,238,071	$ 4,895,949
Patient accounts receivable	898,514	1,095,255
Grant and other receivables	1,149,771	763,483
Pledges receivable	289,104	33,625
Inventory	134,597	100,428
Other current assets	156,514	53,142
Total current assets	10,866,571	6,941,882
Investments	1,997,275	1,373,984
Pledges receivable	135,333	-
Assets limited as to use	1,361,054	1,621,866
Property and equipment, net	5,938,040	5,784,530
Total assets	$ 20,298,273	$15,722,262

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and accrued expenses	$ 283,102	$ 200,449
Accrued payroll and related expenses	955,457	1,199,712
Patient deposits	152,926	137,239
Deferred revenue	116,450	46,628
Provider Relief Funds refundable advance	221,102	-
Paycheck Protection Program refundable advance	1,479,000	-
Current maturities of long-term debt	27,304	-
Total current liabilities	3,235,341	1,584,028
Long-term debt, less current maturities	261,836	-
Total liabilities	3,497,177	1,584,028
Net assets		
Without donor restrictions	13,990,441	12,379,359
With donor restrictions	2,810,655	1,758,875
Total net assets	16,801,096	14,138,234
Total liabilities and net assets	$20,298,273	$15,722,262

The accompanying notes are an integral part of these financial statements.

GREATER SEACOAST COMMUNITY HEALTH

Statements of Operations

Years Ended December 31, 2020 and 2019

	2020	2019
Operating revenue and support		
Net patient service revenue	$11,793,485	$11,318,482
Grants, contracts, and contributions	9,317,881	7,943,253
Other operating revenue	448,537	259,394
Net assets released from restriction for operations	171,899	448,507
Total operating revenue and support	21,731,802	19,969,636
Operating expenses		
Salaries and wages	12,571,717	12,295,009
Employee benefits	2,255,496	2,156,634
Contracted services	985,228	1,080,950
Program supplies	1,519,931	1,324,866
Information technology	755,828	503,376
Occupancy	786,296	787,474
Other	1,276,901	1,125,378
Depreciation	286,651	326,934
Interest expense	3,111	-
Total operating expenses	20,441,159	19,600,621
Operating income	1,290,643	369,015
Other revenue and (losses)		
Investment income	50,806	48,963
Loss on disposal of assets	-	(20,936)
Change in fair value of investments	166,963	157,822
Total other revenue and (losses)	217,769	185,849
Excess of revenue over expenses	1,508,412	554,864
Grants received for capital acquisition	69,701	-
Net assets released from restriction for capital acquisition	32,969	-
Increase in net assets without donor restrictions	$ 1,611,082	$ 554,864

The accompanying notes are an integral part of these financial statements.

GREATER SEACOAST COMMUNITY HEALTH

Statements of Changes in Net Assets

Years Ended December 31, 2020 and 2019

	2020	2019
Net assets without donor restrictions		
Excess of revenue over expenses	$ 1,508,412	$ 554,864
Grants received for capital acquisition	69,701	-
Net assets released from restriction for capital acquisition	32,969	-
Increase in net assets without donor restrictions	1,611,082	554,864
Net assets with donor restrictions		
Contributions	1,098,894	169,687
Investment income	28,158	47,540
Change in fair value of investments	129,596	216,414
Net assets released from restriction for operations	(171,899)	(448,507)
Net assets released from restriction for capital acquisition	(32,969)	-
Increase (decrease) in net assets with donor restrictions	1,051,780	(14,866)
Change in net assets	2,662,862	539,998
Net assets, beginning of year	14,138,234	13,598,236
Net assets, end of year	$16,801,096	$14,138,234

The accompanying notes are an integral part of these financial statements.

GREATER SEACOAST COMMUNITY HEALTH

Statements of Cash Flows

Years Ended December 31, 2020 and 2019

	2020	2019
Cash flows from operating activities		
Change in net assets	$ 2,662,862	$ 539,998
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	286,651	326,934
Equity in loss of limited liability company	-	13,754
Change in fair value of investments	(296,559)	(374,236)
Loss on disposal of assets	-	20,936
Grants and contributions for long-term purposes	(1,144,139)	-
Decrease (Increase) in		
Patient accounts receivable	196,741	397,009
Grant and other receivables	(386,288)	(245,960)
Pledges receivable	(390,812)	229,932
Inventory	(34,169)	42,822
Other current assets	(103,372)	4,845
Increase (decrease) in		
Accounts payable and accrued expenses	82,653	27,597
Accrued salaries and related amounts	(244,255)	124,249
Patient deposits	15,687	(35,866)
Deferred revenue	69,822	39,359
Provider Relief Funds refundable advance	221,102	-
Paycheck Protection Program refundable advance	1,479,000	-
Net cash provided by operating activities	2,414,924	1,111,373
Cash flows from investing activities		
Capital acquisitions	(440,161)	(25,181)
Proceeds from sale of investments	683,784	244,247
Purchase of investments	(749,704)	(331,303)
Net cash used by investing activities	(506,081)	(112,237)
Cash flows from financing activities		
Grants and contributions for long-term purposes	1,144,139	-
Proceeds from long-term debt	300,000	-
Payments on long-term debt	(10,860)	-
Net cash provided by financing activities	1,433,279	-
Net increase in cash and cash equivalents	3,342,122	999,136
Cash and cash equivalents, beginning of year	4,895,949	3,896,813
Cash and cash equivalents, end of year	$ 8,238,071	$ 4,895,949
Supplemental disclosures of cash flow information		
Cash paid for interest	$ 3,111	$ -

The accompanying notes are an integral part of these financial statements.

Organization

Greater Seacoast Community Health (the Organization) is a not-for-profit corporation organized in New Hampshire. The Organization is a Federally Qualified Health Center (FQHC), providing fully integrated medical, behavioral, oral health, recovery services and social support for underserved populations. The Organization is a network of community health centers, which includes Families First Health & Support Center, Goodwin Community Health, and Lilac City Pediatrics, providing healthcare services to individuals living within the greater Seacoast service area.

1. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Organization have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which requires the Organization to report information in the financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of the Organization's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

The Organization is a public charity under Section 501(c)(3) of the Internal Revenue Code (IRC). As a public charity, the Organization is exempt from state and federal income taxes on income earned in accordance with its tax-exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the financial statements.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the State of New Hampshire and the Center for Disease Control, the Organization took steps to create safe distances between both staff and patients. Dental operations were curtailed, open only for emergency care, until services resumed in June 2020. Medical and behavioral health patient visits were done through telehealth when appropriate.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services (HHS). The Organization received PRF in the amount of $221,102 during the year ended December 31, 2020. These funds are to be used for qualifying expenses and to cover lost revenue due to COVID-19 through June 30, 2021. The PRF are considered contributions and are recognized as income when qualifying expenditures or lost revenues have been incurred. The Organization has not incurred qualifying expenses or lost revenue necessary to recognize these contributions during the year ended December 31, 2020, and as a result the funds are reported as a refundable advance on the balance sheet. Management expects to fully expend the funds prior to June 30, 2021.

On May 21, 2020, the Organization qualified for and received a loan in the amount of $1,479,000 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration under the CARES Act and the PPPHCE Act. The principal amount of the PPP is subject to forgiveness, upon the Organization's request, to the extent that the proceeds are used to pay qualifying expenditures, including payroll costs, rent and utilities, incurred by the Organization during a specific covered period. The PPP was fully utilized to pay for qualifying expenditures during the year ended December 31, 2020. The Organization has not yet applied for forgiveness, but is able to do so at any point until the loan matures in May 2022. The Organization expects the full amount of the PPP to be eligible for forgiveness. The PPP is reported as a refundable advance on the balance sheet until forgiveness is received.

Cash and Cash Equivalents

Cash and cash equivalents consist of demand deposits and petty cash funds.

The Organization has cash deposits in major financial institutions which exceed federal depository insurance limits. The Organization has not experienced losses in such accounts and management believes the credit risk related to these deposits is minimal.

Revenue Recognition and Patient Accounts Receivable

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payers (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Organization. The Organization measures the performance obligation for medical, behavioral health, dental and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Organization measures the performance obligation for in-house and contract pharmacy services based on when the prescription is dispensed to the patient. The Organization's performance obligations are satisfied at a point in time.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Organization's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience.

Consistent with the Organization's mission and FQHC designation, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Organization expects to collect based on its collection history with those patients.

The Organization has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payer. In assessing collectability, the Organization has elected the portfolio approach. The portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers (patients). The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payer or group of payers will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. Payer concentrations are disclosed in Note 9.

The Organization bills the patients and third-party payers several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Organization is primarily reimbursed for medical and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Medicaid

The Organization is primarily reimbursed for medical and ancillary services based on prospectively set rates for all FQHC services furnished to a Medicaid beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Dental and certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Other Payers

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Organization is reimbursed based on contractually obligated payment rates for each Current Procedural Terminology code, which may be less than the Organization's public fee schedule.

Patients

The Organization provides care to patients who meet certain criteria under its sliding fee discount program. The Organization estimates the costs associated with providing this care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for the sliding fee discount program. The estimated cost of providing services to patients under the Organization's sliding fee discount program was approximately $1,050,470 and $1,517,244 for the years ended December 31, 2020 and 2019, respectively. The Organization is able to provide these services with a component of funds received through federal and state grants and local support.

For uninsured patients who do not qualify under the Organization's sliding fee discount program, the Organization bills the patient based on the Organization's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

340B Pharmacy Program Revenue

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. This program requires drug manufacturers to provide outpatient drugs to FQHCs and other covered entities at a reduced price. The Organization operates an in-house pharmacy and contracts with other local pharmacies under this program. The contract pharmacies dispense drugs to eligible patients of the Organization and bill commercial insurances on behalf of the Organization. Reimbursement received by the contract pharmacies is remitted to the Organization, less dispensing and administrative fees. The dispensing and administrative fees are costs of the program and not deemed to be implicit price concessions which would reduce the transaction price. The Organization recognizes revenue in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription.

Laws and regulations governing the Medicare, Medicaid and 340B programs are complex and subject to interpretation. Management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare, Medicaid and 340B programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Accounts receivable at January 1, 2019 were $897,258. All such amounts are considered collectible.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. The accounts receivable from patients and third-party payers, net of contractual allowances, were as follows:

	2020	2019
Governmental plans		
Medicare	8 %	7 %
Medicaid	27 %	28 %
Commercial payers	36 %	31 %
Patient	29 %	34 %
Total	100 %	100 %

Grant, Other Receivables, and Deferred Revenue

Grant and other receivables are stated at the amount management expects to collect from outstanding balances. All such amounts are considered collectible.

The Organization receives a significant amount of grants from HHS. For the years ended December 31, 2020 and 2019, grants from HHS (including both direct awards and awards passed through other organizations) represented approximately 64% and 66%, respectively, of grants, contracts and contributions.

A portion of the Organization's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Organization has met the performance requirements or incurred expenditures in compliance with specific contract or grant provisions, as applicable. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue.

The Organization has been awarded cost reimbursable grants that have not been recognized at December 31, 2020 because qualifying expenditures have not yet been incurred as follows:

	Amount	Available Through
Health Center Program	$ 1,274,037	April 30, 2021
CARES Act	643,233	April 3, 2021*
COVID-19 Testing	236,050	May 4, 2021*
Quality Improvement	722	August 31, 2021
Integrated Behavioral Health Services	167,750	August 31, 2021
Oral Health Infrastructure	139,473	April 30, 2022
Expanded Medication Assisted Treatment for Vulnerable Populations	533,606	September 30, 2021
American Rescue Plan Act Funding for Health Centers	3,166,125	March 31, 2023
Total grant funds available	$ 6,160,996	

* Grant extension for additional twelve months can be applied for if funds are not used by the end of the project period.

Inventory

Inventory consists primarily of pharmaceuticals and is stated at the lower of cost or retail. Cost is determined on the first-in, first-out method.

Investments

The Organization reports investments at fair value. Investments include donor endowment funds and assets held for long-term purposes. Accordingly, investments have been classified as non-current assets in the accompanying balance sheets regardless of maturity or liquidity. The Organization has established policies governing long-term investments, which are held within several investment accounts, based on the purposes for those investment accounts and their earnings.

The Organization has elected the fair value option for valuing its investments, which consolidates all investment performance activity within the other revenue and losses section of the statement of operations. The election was made because the Organization believes reporting the activity in a single performance indicator provides a clearer measure of the investment performance. Accordingly, investment income and the change in fair value are included in the excess (deficiency) of revenue over expenses, unless otherwise stipulated by the donor or State Law.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility risks. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the balance sheet.

Investment in Limited Liability Company

The Organization is one of seven members of Primary Health Care Partners, LLC (PHCP). The Organization's investment in PHCP is reported using the equity method. PHCP dissolved on December 31, 2019 and the Organization's remaining capital balance was subsequently distributed to the Organization.

Assets Limited as to Use

Assets limited as to use include investments held for others and donor-restricted contributions to be held in perpetuity and earnings thereon, subject to the Organization's spending policy as further discussed in Note 8.

Property and Equipment

Property and equipment are carried at cost less accumulated depreciation. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. Property and equipment costing less than $5,000 is charged to expense upon purchase.

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as net assets without donor restrictions unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Patient Deposits

Patient deposits primarily consist of payments made by patients in advance of significant dental work based on quotes for the work to be performed.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restriction.

Excess of Revenue Over Expenses

The statement of operations reflects the excess of revenue over expenses. Changes in net assets without donor restrictions which are excluded from the excess of revenue over expenses include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through July 15, 2021, which is the date the financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

2. Availability and Liquidity of Financial Assets

The Organization regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents and a line of credit.

The Organization had working capital of $7,631,230 and $5,357,854 at December 31, 2020 and 2019, respectively. The Organization had average days cash and cash equivalents on hand (based on normal expenditures) of 149 and 93 at December 31, 2020 and 2019, respectively.

Financial assets available for general expenditure within one year were as follows:

	2020	2020
Cash and cash equivalents	$ 8,238,071	$ 4,895,949
Patient accounts receivable, net	898,514	1,095,255
Grant and other receivables	1,149,771	763,483
Financial assets available for current use	$10,286,356	$ 6,754,687

The Organization's goal is generally to have, at the minimum, the Health Resources and Services Administration (commonly known as HRSA) recommended days cash and cash equivalents on hand for operations of 30 days.

3. Pledges Receivable

Pledges receivable are restricted for capital projects that are expected to be placed in service in 2021 and are due as follows:

	2020	2019
Less than one year	$ 289,104	$ 33,625
One to five years	135,333	-
Total	$ 424,437	$ 33,625

A reserve for uncollectible pledges has been established in the amount of $2,000 at December 31, 2020 and 2019. Conditional promises to give are not included as revenue until the conditions are substantially met.

4. Investments and Assets Limited as to Use

Investments, stated at fair value, consisted of the following:

	2020	2019
Long-term investments	$ 1,997,275	$ 1,373,984
Assets limited as to use	1,361,054	1,621,866
Total investments	$ 3,358,329	$ 2,995,850

Assets limited as to use are restricted for the following purposes:

	2020	2019
Assets held in trust under Section 457(b) deferred compensation plans	$ 44,809	$ 36,304
Assets with donor restrictions	1,316,245	1,585,562
Total	$ 1,361,054	$ 1,621,866

Fair Value of Financial Instruments

U.S. GAAP defines fair value as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in an orderly transaction between market participants and also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

U.S. GAAP distinguishes three levels of inputs that may be utilized when measuring fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The following table sets forth by level, within the fair value hierarchy, the Organization's investments at fair value:

	Investments at Fair Value as of December 31, 2020			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 374,694	$ -	$ -	$ 374,694
Municipal bonds	-	165,125	-	165,125
Exchange traded funds	506,873	-	-	506,873
Mutual funds	2,311,637	-	-	2,311,637
Total investments	$ 3,193,204	$ 165,125	$ -	$ 3,358,329

	Investments at Fair Value as of December 31, 2019			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 193,877	$ -	$ -	$ 193,877
Municipal bonds	-	290,796	-	290,796
Exchange traded funds	330,437	-	-	330,437
Mutual funds	2,180,740	-	-	2,180,740
Total investments	$ 2,705,054	$ 290,796	$ -	$ 2,995,850

Municipal bonds are valued based on quoted market prices of similar assets.

5. Property and Equipment

Property and equipment consisted of the following:

	2020	2019
Land	$ 718,427	$ 718,427
Building and improvements	5,943,273	5,857,428
Leasehold improvements	327,532	302,547
Furniture, fixtures, and equipment	2,734,113	2,673,943
Construction in progress	269,161	-
Total cost	9,992,506	9,552,345
Less accumulated depreciation	4,054,466	3,767,815
Property and equipment, net	$ 5,938,040	$ 5,784,530

Property and equipment acquired with Federal grant funds are subject to specific federal standards for sales and other dispositions. In many cases, the Federal government retains a residual ownership interest in the assets, requiring prior approval and restrictions on disposition.

6. Long-Term Debt

Long-term debt consists of the following at December 31:

	2020	2019
2.25% promissory note payable to New Hampshire Health and Education Facilities Authority through July 2030, paid in monthly installments of $2,794, including interest. Note is uncollateralized.	$ 289,140	$ -
Less current portion	27,304	-
Long-term debt, less current portion	$ 261,836	$ -

Maturities of long-term debt for the next five years are as follows at December 31:

2021	$ 27,304
2022	27,925
2023	28,560
2024	29,209
2025	29,873
Thereafter	146,269
Total	$ 289,140

7. Net Assets with Donor Restrictions

Net assets with donor restrictions are available for the following purposes:

	2020	2019
Specific purpose (temporary in nature)		
Program services	$ 448,742	$ 139,688
Construction of new facility	621,232	-
Passage of time (temporary in nature)		
Pledges receivable	424,436	33,625
Earnings from endowment investments	446,567	357,612
Held in perpetuity (permanent in nature)		
Endowment	869,678	1,227,950
Total	$ 2,810,655	$ 1,758,875

Net assets released from net assets with donor restrictions were as follows:

	2020	2019
Satisfaction of purpose - program services	$ 48,514	$ 53,238
Satisfaction of purpose - purchase of capital assets	32,969	-
Passage of time - pledges receivable	54,586	322,064
Passage of time - endowment earnings	68,799	73,205
Total	$ 204,868	$ 448,507

During 2020, the Organization petitioned for and received approval for a change in the intent of one of the Organization's endowment donations so the funds can be used to offset costs associated with the construction of a new facility in Portsmouth, New Hampshire. As a result, the endowment principal was reclassified from net assets with donor restrictions to be held in perpetuity to net assets with donor restrictions with specific purposes.

8. Endowments

Interpretation of Relevant Law

The Organization has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. As a result of this interpretation, the Organization classifies as a donor-restricted endowment (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent donor-restricted endowment gifts, and (c) accumulations to the donor-restricted endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund, if any, is classified as net assets with donor restrictions until those amounts are appropriated for expenditure in a manner consistent with the standard of prudence prescribed by UPMIFA.

In accordance with UPMIFA, the Organization considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

(1) The duration and preservation of the fund;
(2) The purposes of the Organization and the donor-restricted endowment fund;
(3) General economic conditions;
(4) The possible effect of inflation and deflation;
(5) The expected total return from income and the appreciation of investments;
(6) Other resources of the Organization; and
(7) The investment policies of the Organization.

Spending Policy

The Organization has a policy of appropriating for expenditure an amount equal to 5% of the endowment fund's average fair market value over the prior 20 quarters. The earnings on the endowment fund are to be used for operations.

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the Organization to retain as a fund of perpetual duration (underwater). In the event the endowment becomes underwater, it is the Organization's policy to not appropriate expenditures from the endowment assets until the endowment is no longer underwater. There were no such deficiencies as of December 31, 2020 and 2019.

Return Objectives and Risk Parameters

The Organization has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Organization must hold in perpetuity. Under this policy, as approved by the Board of Directors, the endowment assets are invested in a manner that is intended to produce results that exceed or meet designated benchmarks while incurring a reasonable and prudent level of investment risk.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the Organization relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Organization targets a diversified asset allocation that places a balanced emphasis on equity-based and income-based investments to achieve its long-term return objectives within prudent risk constraints.

Endowment Net Asset Composition by Type of Fund

The Organization's endowment consists of assets with donor restrictions only and had the following related activities:

	2020	2019
Endowments, beginning of year	$ 1,585,562	$ 1,394,813
Investment income	28,158	47,540
Change in fair value of investments	129,596	216,414
Spending policy appropriations	(68,799)	(73,205)
Reclassification due to change in purpose restriction	(358,272)	-
Endowments, end of year	$ 1,316,245	$ 1,585,562

9. Patient Service Revenue

Net patient service revenue by payer and program is as follows:

	2020		
	Medical, Behavioral Health and Dental Services	Pharmacy Services	Total
Governmental payers			
Medicare	$ 753,938	$ 229,068	$ 983,006
Medicaid	5,256,020	335,695	5,591,715
Commercial payers	2,603,757	316,667	2,920,424
Patient	442,767	182,912	625,679
Net direct patient service revenue	9,056,482	1,064,342	10,120,824
340B contract pharmacy revenue	-	1,672,661	1,672,661
Net patient service revenue	$ 9,056,482	$ 2,737,003	$ 11,793,485

	2019		
	Medical, Behavioral Health and Dental Services	Pharmacy Services	Total
Governmental payers			
Medicare	$ 927,218	$ 241,341	$ 1,168,559
Medicaid	4,641,469	298,673	4,940,142
Commercial payers	2,806,586	277,352	3,083,938
Patient	470,870	182,195	653,065
Net direct patient service revenue	8,846,143	999,561	9,845,704
340B contract pharmacy revenue	-	1,472,778	1,472,778
Net patient service revenue	$ 8,846,143	$ 2,472,339	$ 11,318,482

10. Functional Expense

The Organization provides various services to residents within its geographic location. Given the Organization is a service organization, expenses are allocated between healthcare, administrative and support and fundraising services based on the percentage of direct care wages to total wages, with the exception of program supplies which are 100% healthcare in nature. Expenses related to providing these services are as follows:

	Healthcare Services	Administrative and Support Services	Fundraising Services	Total
2020				
Salaries and wages	**$ 10,678,936**	**$ 1,479,752**	**$ 413,029**	**$ 12,571,717**
Employee benefits	**1,915,912**	**265,482**	**74,102**	**2,255,496**
Contracted services	**787,581**	**186,356**	**11,291**	**985,228**
Program supplies	**1,519,931**	**-**	**-**	**1,519,931**
Information technology	**642,032**	**88,964**	**24,832**	**755,828**
Occupancy	**667,912**	**92,551**	**25,833**	**786,296**
Other	**1,084,652**	**150,297**	**41,952**	**1,276,901**
Depreciation	**243,493**	**33,740**	**9,418**	**286,651**
Interest expense	**2,643**	**366**	**102**	**3,111**
Total	**$ 17,543,092**	**$ 2,297,508**	**$ 600,559**	**$ 20,441,159**

2019	Healthcare Services	Administrative and Support Services	Fundraising Services	Total
Salaries and wages	$ 10,587,330	$ 1,293,845	$ 413,834	$ 12,295,009
Employee benefits	1,857,078	226,878	72,678	2,156,634
Contract services	890,375	183,127	7,448	1,080,950
Program supplies	1,324,866	-	-	1,324,866
Information technology	433,457	52,955	16,964	503,376
Occupancy	678,094	82,842	26,538	787,474
Other	963,883	103,415	58,080	1,125,378
Depreciation	281,523	34,393	11,018	326,934
Total	$ 17,016,606	$ 1,977,455	$ 606,560	$ 19,600,621

11. Retirement Plans

The Organization has a defined contribution plan under IRC Section 401(k) that covers substantially all employees. For the years ended December 31, 2020 and 2019, the Organization contributed $211,632 and $193,365, respectively, to the plan.

The Organization has established an unqualified deferred compensation plan under IRC Section 457(b) for certain key employees of the Organization. The Organization did not contribute to the plan during the year ended December 31, 2020. The balance of the deferred compensation plan amounted to $44,809 and $36,304 at December 31, 2020 and 2019, respectively.

12. Medical Malpractice Insurance

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of December 31, 2020, there were no known malpractice claims outstanding which, in the opinion of management, will be settled for amounts in excess of both FTCA and additional medical malpractice insurance coverage, nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew the additional medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

13. Lease Commitments

The Organization leases office space and certain other office equipment under noncancelable operating leases. Future minimum lease payments under these leases are as follows:

2021	$ 597,351
2022	629,161
2023	430,556
2024	411,871
2025	335,498
Thereafter	3,885,210
Total	$ 6,289,647

Rental expense amounted to $346,489 and $316,139 for the year ended December 31, 2020 and 2019, respectively.

14. Food Vouchers

The Organization acts as a conduit for the State of New Hampshire's Special Supplemental Food Program for Women, Infants and Children (WIC). The value of food vouchers distributed by the Organization was $1,071,367 and $1,068,417 for the years ended December 31, 2020 and 2019, respectively. These amounts are not included in the accompanying financial statements as they are not part of the contract the Organization has with the State of New Hampshire for the WIC program.

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Board of Directors
Calendar Year 2022

Name/Address	Phone/Email	Occupation
Chair Jennifer Glidden		DHHS Admin. Supervisor **Consumer**
Vice Chair Dennis Veilleux		Accounting Manager
Board Treasurer Jim Sepanski		Financial Executive
Board Secretary Don Chick		Photographer **Consumer**
Laura Belsky		Retired Nurse **Special Population**
Jody Hoffer Gittell		Professor **Consumer**
Valerie Goodwin		Retired Business **Consumer**
Abigail Sykas Karoutas		Attorney **Consumer**
Allison Neal		Education Consultant **Consumer**
Yulia Rothenberg		Education Consultant **Consumer**
Kathy Scheu		Medical/Laboratory Product Sales
Dan Schwarz		Retired Attorney **Consumer**
Jeffrey Segil, MD		Physician-OB/GYN
David B. Staples, DDS		Dentist **Consumer**

TUFTS UNIVERSITY SCHOOL OF MEDICINE
CURRICULUM VITAE AND BIBLIOGRAPHY FORMAT
FOR CLINICAL FACULTY

DATE PREPARED: 08/11/2020
FULL NAME AND DEGREE/S: Joann Buonomano, MD
CURRENT ADMINISTRATIVE TITLE (hospital and /or university if applicable): Chief Medical Officer (CMO) at Greater Seacoast Community Health: Coastal New Hampshire

EDUCATION & TRAINING

Undergraduate

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
1984	BS	Boston University, Boston, MA	Biology

Graduate School and/or Medical School

Year of Degree	*Degree*	*Institution, City, State or Country*	*Discipline*
1989	MD	Boston University School of Medicine	Medicine

Postdoctoral Training

Internship and Residencies:

Years	*Institution, City, State or Country*	*Specialty*
1989-1192	Duke University/FAHEC, Durham, North Carolina	Family Medicine

Fellowships:

Years	*Institution, City, State or Country*	*Specialty*
N/A		

Other Professional Training

Years	*Institution, City, State or Country*	*Discipline*
2016	Certifying Commission Medical Management	Certified Physician Executive (CPE)

Licensure and Certification

Date	*Location*	*Certificate Number*
1995-present	New Hampshire Board of Medicine	9369
2013-2023	American Association of Family Practice	

ACADEMIC APPOINTMENTS

Dates	*Title/Primary or Secondary*	*Department*	*Institution, City, State or Country*
1992-1995	Faculty Appointment 3rd year clerkship site	Family Medicine	University of North Carolina, Chapel Hill, NC
2015-present	Faculty Appointment 3rd year clerkship site	Family Medicine	Boston University School of Medicine, Boston, MA

EMPLOYMENT

Dates	*Title/Position*	*Department*	*Institution, City, State or Country*
1995-2006	Family Medicine Physician		Rural Health Clinic – Ossipee Family Medicine, Ossipee, NH
1995-2014	Family Medicine Physician		Ossipee Family Medicine, Ossipee, NH
2014-2018	Lead Family Medicine Physician		Goodwin Community Health Center, Somersworth, NH
2018-present	Chief Medical Officer (CMO) and physician		Greater Seacoast Community Health, Coastal area, NH

ADMINISTRATIVE APPOINTMENTS

Dates	*Title*	*Department/Program*	*Institution, City, State or Country*
2018-present	Chief Medical Officer (CMO)	Greater Seacoast Community Health	Coastal area, NH

AWARDS AND HONORS

Dates *Award/Honor* *Organization, City, State or Country*
N/A

INSTITUTIONAL COMMITTEE SERVICE

Dates *Role/Committee* *Department/Program* *Institution, City, State or Country*
N/A

EXTERNAL COMMITTEE SERVICE

Local/Regional:

Dates	*Role*	*Organization*
2000-2005	Chairperson	Maternal Child Health Committee, Huggins Hospital, Wolfboro, NH
2011-2012	Chairperson	Clinical Quality Committee, Huggins Hospital, Wolfboro, NH
2012-2013	Chairperson	Out-Patient Division, Huggins Hospital, Wolfboro, NH
2014-present	Board Member	New Hampshire Academy of Family Physicians
2017-present	Board Member	PHO – Health Partners of NH, Inc.
2020-present	President	New Hampshire Academy of Family Physicians

National:

Dates *Role* *Organization*
N/A

International:

Dates *Role* *Organization*
N/A

PROFESSIONAL SOCIETIES

Dates	*Role/ Committee Assignment*	*Organization/Membership*
1995-present	Member	American Academy of Family Physicians
2000-present	Member	New Hampshire Medical Society
2016-2018	Member	American Society of Addiction Medicine
2014-present	Member	American Association of Physician Leadership

GRANT REVIEW ACTIVITIES

Dates	*Role*	*Organization*
N/A		

HEALTH-RELATED ADVOCACY & COMMUNITY SERVICE

Dates	*Organization, City, State or Country*	*Role*
2013	AAFP Delegation to Haiti	Clinical Care Team Member
2013	American lung Association	25 Miles Cycle Participant
2014	Susan G. Komen Foundation	5K Participant
2015	James W. Foley Foundation	5K Participant
2019-present	Yoga Alliance	Certified Yoga Instructor

TRAINING OF STUDENTS/TRAINEES

Students/Mentees:

Dates	*Name of Student/Advisee*	*Level of Training*	*Role and Sponsor (if applicable)*	*Current Position of Advisee*
			Family Medicine 3rd year clerkship site for Boston University School of Medicine, 12 students	

Postdoctoral Trainees:

Past/Current Trainee	*Trainee Name (Where Training Occurred)*	*Postdoc Research Training Period*	*Prior Academic Degree(s)*	*Prior Academic Degree Year(s)*	*Prior Academic Degree Institution(s)*	*Title of Research Project*	*Current Position of Past Trainees / Source of Support of Current Trainees*

EDUCATIONAL ACTIVITIES

Dates Role/Course or Program Title (if applicable) Department Institution City, State or Country
N/A

PRACTICE ACTIVITIES & INNOVATIONS

Dates Activity Sponsor/Institution
N/A

VISITING PROFESSORSHIPS & INVITED ACADEMIC PRESENTATIONS

Visiting Professorships

Dates Department Institution City, State or Country
N/A

Invited Academic Presentations

Local/Regional:
Dates Presentation Title Presentation Type Institution City, State or Country
N/A

National:
Dates Presentation Title Presentation Type Institution City, State or Country
N/A

International:
Dates Presentation Title Presentation Type Institution City, State or Country
N/A

MAJOR RESEARCH INTERESTS

N/A

RESEARCH SUPPORT

Dates Grant Title PI Name Funding Source Grant Number Amount Role
N/A

EDITORIAL BOARDS

Dates Role Board/Publication Name
N/A

AD HOC JOURNAL REVIEWER

Publication Name
N/A

PATENTS

Year Awarded *Patent Number* *Description*
N/A

BIBLIOGRAPHY

a) Refereed Publications:

b) Books Authored/Books Edited:

c) Book Chapters/Invited Reviews:

d) Monographs, Proceedings, and White Papers:

e) Editorials:

f) Letters to the Editor:

g) Case Reports:

h) Theses/Dissertation:

i) Published Abstracts:

j) Non-print Scholarship:

Erin E. Ross

Objective

Obtain a position in Health Care, which will continue to build knowledge and skills from both education and experiences gained.

Qualifications

Mature, energetic individual possessing management experience, organizational skills, multi-tasking abilities, good work initiative and communicates well with internal and external contacts. Proficient in computer skills.

Education

September 1998 – May 2002 **Bachelor of Science in Health Management & Policy**
University of New Hampshire
Durham, New Hampshire 03824

Related Experience

July 2011 – Present **Chief Financial Officer**
Goodwin Community Health

- Responsible for financial oversight of center to include supervision of accountant, bookkeeper, billing department and all clinical administrative staff.
- Assist Executive Director in budgeting process each fiscal year for center.
- Generate and assist with financial aspects of all center grants received.
- Complete on an as needed basis finance analysis's of various agency programs.
- Participate in agency fiscal audit at the end of each fiscal year.
- Member of Board of Directors level Finance Committee

August 2006 – June 2011 **Service Expansion Director**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Winter St location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Assist with the integration of private OB/GYN practice into Avis Goodwin Community Health Center.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.

January 2005 – August 2006 **Site Manager, Dover Location & Front Office Manager**
Avis Goodwin Community Health Center

- Responsible for the overall function of the Dover location of Avis Goodwin Community Health Center.
- Maintain all clinical equipment and order all necessary supplies.
- Assist with the continued integration of dental services and now mental health services to existing primary care services.
- Coordinate the scheduling of all clinical and administrative staff in the office.
- Organize patient outcome data collection and quality improvement measures to monitor multiple aspects and assure sustainability for Avis Goodwin Community Health Center.
- Supervise, hire and evaluate front office staff of both Avis Goodwin Community Health Center locations.
- Develop and implement policies and procedures for the smooth functioning of the front office.

May 2004 – January 2010 **Dental Coordinator**
Avis Goodwin Community Health Center

- Supervise, hire and evaluate dental staff, including Dental Assistant and Hygienists.
- Acted as general contractor during construction and renovation of existing facility for 4 dental exam rooms.
- Responsible for the operations of the dental center, development of educational programs for providers and staff and supervision of the school-based dental program.
- Developed policy and procedure manual, including OSHA and Infection Control protocols.
- Organize patient outcome data collection and quality improvement measures to monitor dental program and assure sustainability.
- Maintain all dental equipment and order all dental supplies.

- Coordinate grant fund requirements to multiple agencies on a quarterly basis.
- Oversee all aspects of billing for dental services, including training existing billing department staff.

July 2003 – May 2004 **Administrative Assistant to Medical Director**
Avis Goodwin Community Health Center

- Assist with Quality Improvement program by attending all meetings, generating monthly minutes documenting all aspects of the agenda and reporting quarterly data followed by the agency.
- Generate a monthly report reflecting provider productivity including number patients seen by each provider and no show and cancellation rates of appointments.
- Served as a liaison between patients and Chief Financial Officer to effectively handle all patient concerns and compliments.
- Established and re-created various forms and worksheets used by many departments.

December 2002 – May 2004 **Billing Associate**
Avis Goodwin Community Health Center

- Organize and respond to correspondence, rejections and payments from multiple insurance companies.
- Created an Insurance Manual for Front Office Staff and Intake Specialists as an aide to educate patients on their insurance.
- Responsible for credentialing and Re-credentialing of providers, including physicians, nurse practitioners and physician assistants, within the agency and to multiple insurance companies.
- Apply knowledge of computer skills, including Microsoft Office, Logician, PCN and Centricity.
- Designed a statement to generate from an existing Microsoft Access database for patients on payment plans to receive monthly statements.
- Assist Front Office Staff during times of planned and unexpected staffing shortages.

June 2002 - December 2002 **Billing Associate**
Automated Medical Systems
Salem, New Hampshire 03079

- Communicate insurance benefits and explain payments and rejections to patients about their accounts.
- Responsible for organizing and responding to correspondence received for multiple doctor offices.
- Determine effective ways for rejected insurance claims to get paid through communicating with insurance companies and patients.
- Apply knowledge of computer skills, including Microsoft Office, Accuterm and Docstar.

Work Experience

October 1998 – May 2002 **Building Manager**
Memorial Union Building – UNH
Durham, New Hampshire 03824

- Recognized as a Supervisor, May 2001-May 2002.
- Supervised Building Manager and Information Center staff.
- Responsible for managing and documenting department monetary transactions.
- Organized and led employee meetings on a weekly basis.
- Established policies and procedures for smooth functioning of daily events.
- Oversaw daily operations of student union building, including meetings and campus events.
- Served as a liaison between the University of New Hampshire, students, faculty and community.
- Organized and maintained a weekly list of rental properties available for students.
- Developed and administered new ideas for increased customer service efficiency.

References

Available upon request

JANET M. LAATSCH

Objective: To utilize my leadership skills to create a dynamic, sustainable non-profit organization.

WORK EXPERIENCE:

Greater Seacoast Community Health, **2018-Present**
Somersworth, Portsmouth, Rochester, NH
Chief Executive Officer

Accomplishments:

- Successful merger of two FQHC's and one private practice in 2018
- Secured a new location for Portsmouth by 6/30/21
- Improved sustainability of the Portsmouth and Rochester locations
- Increased retention rate to 98% in 2019 and 2020

Goodwin Community Health (GCH)
Somersworth, NH
Chief Executive Officer **2005-2018**

Accomplishments:

- Successfully retained all Directors and Physicians
- Built relationships with donors, foundations, local and state representatives and other non-profit and for-profit organizations
- Retention of an active Board of Directors
- Improvement of patient outcomes
- Successfully implemented mental health integration program
- Successfully acquired a for-profit mental health organization
- Developed a new partnership with Noble High School
- Developed a new partnership with Southeastern NH Services
- Obtained new grant funding of over $7.0 million
- Expansion of donor base
- Development of a corporate compliance program
- Merged the public health and safety council under AGCHC

Responsibilities:

- Oversight of operations, finance, personnel and fund development
- Grant writing and donor development
- New business development
- Compliance with all federal and state regulations
- Build relationships and partnerships locally and statewide
- Strategic planning
- Report directly to the Board of Directors

Finance Director **2002-2005**

Accomplishments:

- Brought in over $3.0 million in grant funds for the organization
- Obtained Federally Qualified Health Center status in 2004
- Designed and implemented a successful new dental program

- Achieved a financial surplus annually

Responsibilities:

- Responsible for all financial transactions, billing, collections, patient accounts
- Strategic planning as it relates to capital funding
- Budget development, cost/benefit analysis of existing programs and potential new programs
- Development and implementation of an annual development plan
- Research, write, submit and provide follow-up reports for grant funds
- Oversee human resource functions of the organization

Grant Writer/Per Diem Nurse **2001-2002**

Grant Writing Services,
N. Hampton, NH
Sole Proprietor **1999-2001**

Accomplishments:

- Successfully researched and submitted grants for health and educational organizations totaling over $150k

Responsibilities:

- Research private, industry, state and federal funds for non-profit organizations

North Shore Medical Center (Partners Health Care) **1991-1999**
Salem, MA
Acting Chief Operations Officer for the
North Shore Community Health Center **1997-1999**

Accomplishments:

- Successfully submitted their competitive Federal grant and other state grants
- Recruited a medical director and re-negotiated existing provider contracts to include productivity standards
- Re-designed operations to improve productivity
- Incorporated the hospital's medical residency program into the Health Center
- Achieved a financial surplus for the first time in five years
- Developed a quality improvement program and framework

Responsibilities:

- Placed at the Health Center by the North Shore Medical Center to revamp operations and improve the cash flow for the organization
- Reported directly to the Board of Directors

EDUCATION:

University of New Hampshire:	M.B.A.	
Durham, N.H.	Concentration in Finance	**1991**
Northern Michigan University:	B.S.N.	
Marquette, M.I.	Minor in Biology	**1981**

LICENSES/CERTIFICATES:

Real Estate Broker
N.H. Nursing License

PROFESIONAL:
Member of the National Association of Community Health Centers
Previous Board member of the United Way of the Greater Seacoast
Treasurer for the Health and Safety Council of Strafford County
Board member of the Community Health Network Access (CHAN)
Board member of the Rochester Rotary, slotted for President in 2011

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary Amount Paid from this Contract
Janet Laatsch	Chief Executive Officer	$0
Erin Ross	Chief Financial Officer	$0
Joann Buonomano, MD	Chief Medical Officer	$0

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-06)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name HealthFirst Family Care Center, Inc.		1.4 Contractor Address 841 Central St. Franklin, NH 03235	
1.5 Contractor Phone Number (603) 934-0177	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $597,648
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Russell Keene Date: 5/20/2022		1.12 Name and Title of Contractor Signatory Russell Keene — President/CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt Date: 5/20/2022		1.14 Name and Title of State Agency Signatory Iain Watt — Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino On: 5/20/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials DS RK
Date 5/20/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

DS

Contractor Initials

Date 5/20/2022

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

Contractor Initials RK

Date 5/20/2022

Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only; and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

Contractor Initials DS

Date 5/20/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population, in

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accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Well-Care Visits, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Measuring Developmental Screening, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

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license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*HealthFirst Family Care Center, Inc.*
Budget Request for:	*Integrated Primary Care*
Budget Period	*Date of G&C Approval - 6/30/2022*
Indirect Cost Rate (if applicable)	10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$16,437
2. Fringe Benefits	$3,945
3. Consultants	$0.00
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0.00
5.(a) Supplies - Educational	$0.00
5.(b) Supplies - Lab	$0.00
5.(c) Supplies - Pharmacy	$0.00
5.(d) Supplies - Medical	$1,351
5.(e) Supplies Office	$0.00
6. Travel	$0.00
7. Software	$0.00
8. (a) Other - Marketing/Communications	$0.00
8. (b) Other - Education and Training	$0.00
8. (c) Other - Other (specify below)	
Other Language Interpretation Services	$0.00
Other (please specify)	$0.00
Other (please specify)	$0.00
Other (please specify)	$0.00
9. Subrecipient Contracts	$0.00
Total Direct Costs	$21,733
Total Indirect Costs	$2,173
TOTAL	**$23,906.00**

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Contractor Initials

5/20/2022
Date

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*HealthFirst Family Care Center, Inc.*
Budget Request for:	*Integrated Primary Care*
Budget Period	*7/1/22 - 6/30/23 (SFY 23)*
Indirect Cost Rate (if applicable)	10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$178,402
2. Fringe Benefits	$42,816
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$22,074
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$10,000
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other Language Interpretation Services	$7,500
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$260,792
Total Indirect Costs	$26,079
TOTAL	**$286,871.00**

Contractor Initials DS RK

Date 5/20/2022

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*HealthFirst Family Care Center, Inc.*
Budget Request for:	*Integrated Primary Care*
Budget Period	*7/1/23 - 6/30/24 (SFY 24)*
Indirect Cost Rate (if applicable)	10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$178,402
2. Fringe Benefits	$42,816
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$22,074
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$10,000
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other Language Interpretation Services	$7,500
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$260,792
Total Indirect Costs	$26,079
TOTAL	**$286,871**

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Contractor Initials

5/20/2022

Date

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

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Vendor Initials _____
5/20/2022
Date _____

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

DocuSigned by:
Russell Keene
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5/20/2022
Date

Name: Russell Keene
Title: President/CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/20/2022
Date

DocuSigned by:
Russell Keene
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Name: Russell Keene
Title: President/CEO

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Vendor Initials
5/20/2022
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials DS RK

Date 5/20/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

DocuSigned by:
Russell Keene
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5/20/2022
Date

Name: Russell Keene
Title: President/CEO

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RK

Contractor Initials

5/20/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:
Russell Keene
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5/20/2022
Date

Name: Russell Keene
Title: President/CEO

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Russell Keene
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5/20/2022
Date

Name: Russell Keene
Title: President/CEO

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Contractor Initials

5/20/2022
Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

Contractor Initials RK

Date 5/20/2022

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	HealthFirst Family Care Center
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Russell Keene
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	President/CEO
Title of Authorized Representative	Title of Authorized Representative
5/20/2022	5/20/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Russell Keene
7F5EC4A20E4E401...

5/20/2022
Date

Name: Russell Keene
Title: President/CEO

DS
RK
Contractor Initials

5/20/2022
Date

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 026459417

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

Enabling Services Work Plan Agency Name: HealthFirst Family Care Center Name and Role of Person(s) Completing Work Plan: Alisha Nadeau, MSN, RN, CNL; Senior Director of Clinical Operations			
Enabling Services Focus Area: To address social determinants of health (SDOH) and reduce health disparities.			
Project Goal: Have dedicated staff and community partnerships that equip us to provide education and resources to our patients.			
Project Objective: To continue to provide enabling services as a key component of a comprehensive community health center model of care.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Provide daily access to the patient advocates in both office locations, expanding telehealth access, increase use of online and DocuSign systems, to create ease of access as a resource for patients without requiring an in-person visit	COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Medical Interpreters CTS and other transportation services	The Practice Manager will track volume of Patient Advocate and telehealth visits on a monthly basis and report visit volume to the management team.	March 2022
Increase our 340b pharmacy partnership program by adding an additional pharmacy to the HF 340b pharmacy program by January 2023	Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager HF 340b Pharmacy program	The CFO will track progress and report to the management team the status of adding a Pharmacy to the HF pharmacy partner program.	January 2023
Increase our community outreach efforts with offering additional counselor involvement	Behavioral Health Clinicians COVID CHW MAT Team	The Behavioral Health Manager will track progress with the counselors for community	September 2022

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

with at least one additional school district (ie Belmont School district) by Sept 2022	Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager	outreach to include an additional school district (ie: Belmont School district(s)). Update will be provided at the Management Team Meeting.	
Update our resource material for dental care access in our catchment area to include school based dental services by April 2022. This goal will be affected by the school's agreement to have this collaborative effort offered and COVID pandemic restrictions to access schools.	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Dental Resources and Hygienist	The Practice Manager will track progress with dental referrals and number of patients in the School Dental Program. An update will be provided to the Management Team on # of patients and schools supporting participation quarterly.	April 2022
Provide additional training and education to administrative personnel each quarter at their team meetings. The Patient Advocate and/or Quality Project nurse will present information that will equip our team to better guide the patients. Team agenda will include the Patient Advocate and/or Quality nurse starting in April 2022 and will include focus on the following: Services covered by a Patient Advocate Services covered by the COVID CHW Services covered by a CRSW	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff Dental Resources and Hygienist	The Practice Manager will schedule the Patient Advocate & Quality Project Nurse, set the agenda, and document minutes of the Patient Services Team meetings. The minutes (including handouts) will be saved on a shared drive for staff to refer to. An update will be provided to the Management Team when complete.	Quarterly starting in April 2022

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

Sliding Fee Scale determination process Update on community collaborative efforts and services available in our community (such as housing, education, food & nutrition) BCCP program awareness and how to offer this to our uninsured women patients			
Interpreter's annual contract will be renewed in 2022 to continue to provide translation services for our patients.	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Medical Interpreters CTS and other transportation services Breast and Cervical Cancer program (BCCP) staff Dental Resources and Hygienist HF 340b Pharmacy program	The Practice Manager will track progress with the interpretation and language services contracts. An update will be provided to the Management Team once completed.	June 2022
Participation in cross-agency multi-disciplinary teams working on community wellness and	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers	The Practice Manager and Senior Director of Clinical Operations will schedule the interdisciplinary	Quarterly starting in March 2022

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

interagency communication and collaborative education and information projects.	COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Medical interpreters CTS and other transportation services Breast and Cervical Cancer program (BCCP) staff Dental Resources and Hygienist HF 340b Pharmacy program	team meetings, set the agenda, and document minutes of the cross-agency meetings. The minutes (including handouts) will be saved on a shared drive for staff to refer to. An update will be provided to the Management Team when complete.	
Collect PRAPARE screening questions of SDOH needs during patient intake process and add the rescreening of patients to their annual forms that need to be completed every year	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Senior Director of Clinical Operations will prepare a handout of the PRAPARE screening questions to be added to the intake packets. The Practice Manager will share the SDOH questions with the intake team to add to the annual and New Patient packets	October 2022
Instruct the Medical Assistants (MAs) to import the PRAPARE screening answers into the	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers	The PRAPARE screening question handout will be scanned to the MA's desktop for documentation	October 2022

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

patient's chart within the EMR during chart prep before the New Patient Appointment	COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager	into the patient's chart. The PRAPARE screening tool is already integrated within our EMR for electronic documentation purposes	
Have the MA review the patient's PRAPARE screening answers during the New Patient Appointment and ask patient if (s)he would like a referral for services with our Patient Advocate, COVID CHW, CRSW, or social worker	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	The PRAPARE screening questions will be reviewed by the MA at the New Patient Appt and their SDOH needs confirmed If necessary and willing, the MA will refer the patient to the most appropriate in-house employee to help address their needs- Patient Advocate, Certified Application Specialist, COVID CHW, CRSW, MAT, social worker, or BH clinician	October 2022
Add the PRAPARE screening to patient's annual physicals for MAs to rescreen patients for SDOH needs	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	The integrated EMR PRAPARE screening tool form will be added to the necessary appointment types so the MA will be prompted to ask the patient about their SDOH needs on an annual basis, at a minimum	January 2023

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise, and resubmit to the Department for review and/or approval. Work Plan Revisions submitted: _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise, and resubmit to the Department for review and/or approval. Work Plan Revisions submitted: _____Yes ____No	

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

July 2023 Project Update SFY23 Outcome (Insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update SFY23 Narrative: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. Work Plan Revisions submitted: _____Yes ____No	
July 2023 Project Update SFY23 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise, and	

Attachment #1 – Screening and Referrals for SDOH

Appendix D – Enabling Service Work Plan and Progress Report Template

resubmit to the Department for review and/or approval. Work Plan Revisions submitted: ____Yes ____No	
July 2024 Project Update SFY24 Outcome (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update SFY24 Narrative: If met–Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update SFY24 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

Enabling Services Work Plan Agency Name: HealthFirst Family Care Center Name and Role of Person(s) Completing Work Plan: Alisha Nadeau, MSN, RN, CNL; Senior Director of Clinical Operations			
Enabling Services Focus Area: Implement ACES (Adverse Childhood Experiences) screening in the pediatric/adolescent patient population			
Project Goal: Have dedicated staff and evidence-based screening tools that equip us to provide education and resources to our patients regarding the impacts and effects childhood trauma can have on development and services necessary for the patient			
Project Objective: To continue to provide trauma informed care, care coordination, appropriate referrals, and effective services for our patients as a key component of a comprehensive community health center model of care.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Research evidence-based ACES screening tools appropriate for primary care integration	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Develop a work group to research and evaluate ACES screening tools appropriate for primary care agencies Choose one or two ACES screening tools to try with a Pilot group	October 2022
Ensure sufficient staff to conduct ACES screening according to integrated model	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians	Senior Director of Clinical Operations to grow and develop the MA and nursing teams to ensure appropriate staff available to conduct the screenings during medical patient visits	December 2022

Contractor Initials RK (DS)

Date 5/20/2022

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

	Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Behavioral Health Manager to grow and develop the behavioral health team to ensure appropriate staff available to conduct the screenings during behavioral health patient visits	
Provide training to integrated care and behavioral health team to ensure fidelity to the ACES model	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Annual review of ACES screening protocol Semi-annual re-education of all clinical and behavioral health staff on ACES screening protocol Semi-annual performance updates during clinical and behavioral health staff meetings QA Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee on a quarterly basis to identify improvement opportunities Review annual performance with PCPs Measure results will be reported to BOD QI Subcommittee semi-annually	April 2023
Modify and/or adapt current Electronic Medical Records (EMR) systems to track ACES completions, actions, recommendations, and follow-ups	Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager CHAN	Senior Director of Clinical Operations and the Quality Nurse Coordinator will work with CHAN to get the selected ACES screening form uploaded into the EMR for documentation purposes	January 2023

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

Use ACES in the EMR to bill for trauma informed care services	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Billing and Finance Team	HFFCC billing and finance team to research billing and reimbursement opportunities for the medical and BH clinicians to be reimbursed for ACES screening If possible, the appropriate orders and CPT codes will be uploaded into our EMR for clinician use and billing purposes	January 2023
Coordinate care between internal and external treatment partners that provide trauma informed care services based on ACES findings not available primary care site	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	The Senior Director of Clinical Operations will track progress with external referrals and number of patients referred for services. An update will be provided to the Management Team on # of patients quarterly The Behavioral Health Manager will track referrals sent via UniteUs platform	April 2023
Test ACES fidelity with subset of target population prior to full implementation with all pediatric and adolescent patients	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team	Determine the appropriate pilot team to test the ACES screening question for the target population	June 2023

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

	Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Complete PDSA cycles to ensure the questionnaire's integration within the clinical team's workflow is sustainable Once achieved, roll out the ACES screening questions to the rest of the pediatric and adolescent patient population at all sites of care	

Enabling Service Work Plan Progress Report Template. Enabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. Work Plan Revisions submitted: ____Yes ____No	

Contractor Initials DS RK

Date 5/20/2022

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. Work Plan Revisions submitted: _____Yes ____No	
July 2023 Project Update SFY23 Outcome (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update SFY23 Narrative: If met–Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. Work Plan Revisions submitted: _____Yes ____No	

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

July 2023 Project Update SFY23 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval. Work Plan Revisions submitted: ____Yes ____No	
July 2024 Project Update SFY24 Outcome (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update SFY24 Narrative: If met--Explain what happened during the year that contributed to the success.	

Attachment #2 – Implement Adverse Childhood Experiences (ACES) Screening in the Pediatric/Adolescent Patient Population

Appendix D – Enabling Service Work Plan and Progress Report Template

If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update SFY24 Patient Success Story: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

DS

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

Quality Improvement Work Plan Agency Name: HealthFirst Family Care Center Name and Role of Person(s) Completing Work Plan: Alisha Nadeau, MSN, RN, CNL; Senior Director of Clinical Operations			
MCH Performance Measure: Adolescent Well-Care Visit: Percentage of adolescents 12-21 years of age, who had at least one comprehensive well-care visit/CPE with a PCP or an OB/GYN practitioner during the measurement year			
Project Objective: To enhance adolescent health by assuring recommended annual adolescent well-visits, with the hopes of improving the availability of and access to healthcare to maintain the infrastructure of safety net providers and services, decreasing adolescent overweight and obesity, and decreasing the use and abuse of alcohol, tobacco, and other substances among adolescents			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Annual review of adolescent well-care performance measure and protocol	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	March 2022
Semi-annual re-education of all clinical staff on adolescent well-	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI	March 2022

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

care performance measure and protocol	COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance The action plan will be reassessed and re-evaluated if the semi-annual target is not met or the quarterly reviews indicate lack of progress or need of revision Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	
Nursing and MA staff to review quarterly reports to identify patients in need of adolescent well-care visits, will contact the family, and schedule appointments	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help	March 2022, quarterly thereafter

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

		initiate discussion on improving performance The action plan will be reassessed and re-evaluated if the semi-annual target is not met or the quarterly reviews indicate lack of progress or need of revision Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	
QI staff will review monthly insurance reports and reach out to all patients in need of well-care visits	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance The action plan will be reassessed and re-evaluated if the semi-annual target is not met or the quarterly reviews indicate lack of progress or need of revision	March 2022, monthly thereafter

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

		Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	
Improve daily use of protocol assessment tool and 'check protocols' button in the EMR by clinical staff to identify adolescents in need of well-care visit	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance The action plan will be reassessed and re-evaluated if the semi-annual target is not met or the quarterly reviews indicate lack of progress or need of revision Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	March 2022
Improve use of pre-planning procedure and Care Management Reports to document the last date of adolescent well-care visit, which will trigger the check-out staff to	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify	March 2022

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

schedule the well-care visit before patient leaves the office	Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance The action plan will be reassessed and re-evaluated if the semi-annual target is not met or the quarterly reviews indicate lack of progress or need of revision Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	
During acute visits, parents and adolescents will be counseled and encouraged to come in for annual health visits by their PCPs and nurses	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance	March 2022

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2022 Progress Report– • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report– • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative:** If met–Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	

Attachment #4 – Adolescents Well-Care Visits

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

Quality Improvement Work Plan Agency Name: **HealthFirst Family Care Center** Name and Role of Person(s) Completing Work Plan: **Alisha Nadeau, MSN, RN, CNL; Senior Director of Clinical Operations**			
MCH Performance Measure: Developmental Screening Measure: Percent of children who reached 30 months by the end of the reporting period, and who were screened for autism using the MCHAT at least once between the ages of 16-30 months			
Project Objective: To enhance pediatric health and increase appropriate referrals to specialty services by assuring recommended evidence-based developmental screenings are completed by the recommend age guidelines			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Ensure sufficient staff to conduct MCHAT screening according to integrated model	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Senior Director of Clinical Operations to grow and develop the MA and nursing teams to ensure appropriate staff available to conduct the screenings during medical patient visits Behavioral Health Manager to grow and develop the behavioral health team to ensure appropriate staff available to conduct the screenings during behavioral health patient visits	July 2022
Provide training to integrated care and behavioral health team to ensure fidelity to the MCHAT screening	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators	Annual review of MCHAT screening protocol Semi-annual re-education of all clinical and behavioral health staff on MCHAT screening protocol	September 2022

Contractor Initials RK (DS)

Date 5/20/2022

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

	Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Semi-annual performance updates during clinical and behavioral health staff meetings QA Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee on a quarterly basis to identify improvement opportunities Review annual performance with PCPs Measure results will be reported to BOD QI Subcommittee semi-annually	
Modify and/or adapt current Electronic Medical Records (EMR) systems to track MCHAT completions, actions, recommendations, and follow-up	Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager CHAN	Senior Director of Clinical Operations and the Quality Nurse Coordinator will work with CHAN to get the MCHAT screening form updated in the EMR for documentation purposes	September 2022
Coordinate care between internal and external treatment partners that provide autism informed care, diagnoses, and services based on MCHAT findings that is not available primary care site	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager	The Senior Director of Clinical Operations will track progress with external referrals and number of patients referred for services. An update will be provided to the Management Team on # of patients quarterly The Behavioral Health Manager will track referrals sent via UniteUs platform, if applicable	December 2022

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

	Patient Advocates and Certified Application Specialists		
Test MCHAT fidelity with target population and one pediatric medical provider prior to full implementation with all pediatric patients	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Behavioral Health Clinicians Administrative personnel- Intake and referral coordinators Management personnel – CEO, CFO, Clinical Director, HR Director and Practice Manager Patient Advocates and Certified Application Specialists	Determine the appropriate pilot team to test the MCHAT screening question for the target population Complete PDSA cycles to ensure the questionnaire's integration within the clinical team's workflow is sustainable Once achieved, roll out the MCHAT screening questions to the rest of the pediatric and adolescent patient population at all sites of care	December 2022
Annual review of MCHAT screening protocol and semi-annual re-education of all clinical staff on MCHAT screening protocol	Clinical personnel- Nurses, Medical Assistants (MAs), Quality Nurses, and medical providers COVID CHW MAT Team Administrative personnel- Intake and referral coordinators Patient Advocates and Certified Application Specialists Breast and Cervical Cancer program (BCCP) staff	QA/QI Nurse Coordinator will review data on a quarterly basis and share with the Staff QI Committee and in clinical staff meetings to identify opportunities for improvement and potential tests of change Each Provider will be given his/her individual measure performance percentages quarterly, which will be reviewed with all other clinical staff to help initiate discussion on improving performance Measure results will be reported to the BOD QI Subcommittee on a quarterly basis	January 2023

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2022 Progress Report– • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report– • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	___Yes ___No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	

Contractor Initials DS

Date 5/20/2022

Attachment #5 – Measuring Developmental Screening

Appendix J – Quality Improvement Project Work Plan and Progress Report Template

July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	___Yes ___No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

Contractor Initials DS RK

Date 5/20/2022

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

Attachment #6 – Performance Measures

and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

DS

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

DS

5/20/2022

Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

DS

5/20/2022

Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

DS

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS

5/20/2022

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that HEALTHFIRST FAMILY CARE CENTER, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on April 23, 1996. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **248976**

Certificate Number: **0005772689**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 6th day of May A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE OF AUTHORITY

I, ____Mike Stanley_____, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of _____Health First Family Care Center_____.
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on ___May 11, ~~2020~~_____, 20~~22~~, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That ____Russell Keene CEO or James Wells_, Director_____ (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of __HealthFirst Family Care Center_____ to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated:___5.12.22_____

Signature of Elected Officer
Name: MICHAEL STANLEY
Title: BOARD CHAIR

HEALFIR-01 BCHASSE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/15/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # AGR8150 Clark Insurance One Sundial Ave Suite 302N Manchester, NH 03103	CONTACT NAME: PHONE (A/C, No, Ext): (603) 622-2855 FAX (A/C, No): (603) 622-2854 E-MAIL ADDRESS: info@clarkinsurance.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Citizens Ins Co of America	31534
INSURED HealthFirst Family Care Center, Inc. 841 Central St Franklin, NH 03235	INSURER B : AmTrust Financial Services.Inc.	
	INSURER C : AIX Specialty Insurance Co	12833
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR			OBVA044172	7/1/2021	7/1/2022	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY [ ] SCHEDULED AUTOS			OBVA044172	7/1/2021	7/1/2022	BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	[ ] UMBRELLA LIAB X OCCUR						EACH OCCURRENCE	$ 1,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE			OBVA044172	7/1/2021	7/1/2022	AGGREGATE	$ 1,000,000
	[ ] DED [ ] RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N [ ]	N/A		SWC1345444	7/1/2021	7/1/2022	E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
C	Professional Liab			L3V D302912 05	7/1/2021	7/1/2022	Each Incident	1,000,000
C	Professional Liab			L3V D302912 05	7/1/2021	7/1/2022	Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

NH DHHS
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Nancy Ruth

HEALTHFIRST

Our Mission

It is the mission of Health First Family Care Center to provide high quality primary healthcare, treatment, prevention, and education services required by the residents of the service area, regardless of ability to pay or insurance status.

Health First coordinates and cooperates with other community and regional health care providers to assure the people of the region the fullest possible range of health and prevention services.

BerryDunn

HEALTH FIRST

FINANCIAL STATEMENTS

and

REPORTS IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS* AND THE UNIFORM GUIDANCE

September 30, 2021 and 2020

With Independent Auditor's Reports

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
HealthFirst Family Care Center, Inc.

Report on Financial Statements

We have audited the accompanying financial statements of HealthFirst Family Care Center, Inc., which comprise the balance sheets as of September 30, 2021 and 2020, and the related statements of operations and changes in net assets, functional expenses, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of HealthFirst Family Care Center, Inc. as of September 30, 2021 and 2020, and the results of its operations, changes in its net assets and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 1 to the financial statements, during the year ended September 30, 2021, HealthFirst Family Care Center, Inc. adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance. Our opinion is not modified with respect to this matter.

Other Matter

Our audit was conducted for the purposes of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated January 12, 2022 on our consideration of HealthFirst Family Care Center, Inc.'s internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of HealthFirst Family Care Center, Inc.'s internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HealthFirst Family Care Center, Inc.'s internal control over financial reporting and compliance.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
January 12, 2022

HEALTHFIRST FAMILY CARE CENTER, INC.

Balance Sheets

September 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 2,946,398	$ 2,135,630
Short-term certificates of deposit	935,086	933,483
Patient accounts receivable	736,592	672,618
Grants receivable	113,256	275,519
Other current assets	701	43,295
Total current assets	4,732,033	4,060,545
Long-term certificates of deposit	56,742	55,842
Assets limited as to use	195,190	186,171
Property and equipment, net	1,606,940	1,598,199
Total assets	$ 6,590,905	$ 5,900,757

LIABILITIES AND NET ASSETS

Current liabilities		
Line of credit	$ -	$ 14,835
Accounts payable and accrued expenses	200,020	125,787
Accrued payroll and related expenses	501,192	530,489
Due to third-party payers	296,297	-
Deferred revenue	68,372	50,190
Provider Relief Funds refundable advance	-	502,578
Paycheck Protection Program refundable advance	-	10,000
COVID-19 Emergency Healthcare System Relief Fund refundable advance	-	250,000
Current portion of long-term debt	60,162	57,826
Total current liabilities	1,126,043	1,541,705
Long-term debt, less current portion	1,377,667	1,436,637
Total liabilities	2,503,710	2,978,342
Net assets		
Without donor restrictions	4,087,195	2,922,415
Total liabilities and net assets	$ 6,590,905	$ 5,900,757

The accompanying notes are an integral part of these financial statements.

HEALTHFIRST FAMILY CARE CENTER, INC.

Statements of Operations and Changes in Net Assets

Years Ended September 30, 2021 and 2020

	2021	2020
Operating revenue		
Net patient service revenue	$ 5,308,955	$ 4,455,949
Grants, contracts and contributions	3,244,583	2,196,112
Paycheck Protection Program	-	635,100
Other operating revenue	156,715	197,724
Total operating revenue	8,710,253	7,484,885
Operating expenses		
Salaries and wages	4,155,669	3,865,859
Employee benefits	918,513	814,845
Program supplies	497,066	299,546
Contracted services	606,227	449,147
Occupancy	145,524	90,787
Information technology	561,253	493,594
Other	547,518	422,081
Depreciation	66,230	65,363
Interest	58,205	65,503
Total operating expenses	7,556,205	6,566,725
Excess of revenue over expenses	1,154,048	918,160
Grants for capital acquisition	10,732	42,833
Increase in net assets without donor restrictions	1,164,780	960,993
Net assets, beginning of year	2,922,415	1,961,422
Net assets, end of year	$ 4,087,195	$ 2,922,415

The accompanying notes are an integral part of these financial statements.

HEALTHFIRST FAMILY CARE CENTER, INC.

Statements of Functional Expenses

Years Ended September 30, 2021 and 2020

	2021		
	Healthcare Services	Support Services	Total
Salaries and wages	$ 3,461,919	$ 693,750	$ 4,155,669
Employee benefits	765,175	153,338	918,513
Program supplies	497,066	-	497,066
Contracted services	479,050	127,177	606,227
Occupancy	121,230	24,294	145,524
Information technology	467,557	93,696	561,253
Other	456,115	91,403	547,518
Depreciation	55,174	11,056	66,230
Interest	48,488	9,717	58,205
Total operating expenses	$ 6,351,774	$ 1,294,802	$ 7,556,205

	2020		
	Healthcare Services	Support Services	Total
Salaries and wages	$ 3,158,068	$ 707,791	$ 3,865,859
Employee benefits	665,657	149,188	814,845
Program supplies	299,546	-	299,546
Contracted services	350,088	99,059	449,147
Occupancy	74,165	16,622	90,787
Information technology	403,223	90,371	493,594
Other	344,804	77,277	422,081
Depreciation	53,396	11,967	65,363
Interest	53,510	11,993	65,503
Total operating expenses	$ 5,402,457	$ 1,073,897	$ 6,566,725

The accompanying notes are an integral part of these financial statements.

HEALTHFIRST FAMILY CARE CENTER, INC.

Statements of Cash Flows

Years Ended September 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	$ 1,164,780	$ 960,993
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	66,230	65,363
Grants for capital acquisition	(10,732)	(42,833)
(Increase) decrease in the following assets		
Patient accounts receivable	(63,974)	(47,269)
Grants receivable	162,263	12,825
Other current assets	42,594	32,459
Increase (decrease) in the following liabilities		
Accounts payable and accrued expenses	74,233	66,722
Accrued payroll and related expenses	(29,297)	217,052
Due to third-party payers	296,297	-
Deferred revenue	18,182	16,557
Provider Relief Funds refundable advance	(502,578)	502,578
Paycheck Protection Program refundable advance	(10,000)	10,000
COVID-19 Emergency Healthcare System Relief Fund refundable advance	(250,000)	250,000
Net cash provided by operating activities	957,998	2,044,447
Cash flows from investing activities		
Capital expenditures	(74,971)	(42,833)
Purchases of certificates of deposit, net of reinvestments	(2,503)	(754,916)
Net cash used by investing activities	(77,474)	(797,749)
Cash flows from financing activities		
Repayments on line of credit	(14,835)	(14,952)
Grants for capital acquisition	10,732	42,833
Principal payments on long-term debt	(56,634)	(54,362)
Net cash used by financing activities	(60,737)	(26,481)
Net increase in cash and cash equivalents and restricted cash	819,787	1,220,217
Cash and cash equivalents and restricted cash, beginning of year	2,321,801	1,101,584
Cash and cash equivalents and restricted cash, end of year	$ 3,141,588	$ 2,321,801

HEALTHFIRST FAMILY CARE CENTER, INC.

Statements of Cash Flows (Concluded)

Years Ended September 30, 2021 and 2020

	2021	2020
Composition of cash and cash equivalents and restricted cash, end of year		
Cash and cash equivalents	$ 2,946,398	$ 2,135,630
Assets limited as to use	195,190	186,171
	$ 3,141,588	$ 2,321,801
Supplemental cash flow disclosure		
Cash paid for interest	$ 58,205	$ 65,503

The accompanying notes are an integral part of these financial statements.

Organization

HealthFirst Family Care Center, Inc. (the Organization) is a not-for-profit corporation organized in the State of New Hampshire. The Organization is a Federally Qualified Health Center (FQHC), providing high-quality primary healthcare, treatment, prevention, and education services required by the residents in the Twin Rivers Region of New Hampshire, commensurate with available resources, and coordinating and cooperating with other community and regional healthcare providers to ensure the people of the region the fullest possible range of health services.

1. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Organization have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which require the Organization to report information in the financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of the Organization's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity. There were no net assets with donor restrictions at September 30, 2021 and 2020.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

The Organization is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, the Organization is exempt from state and federal income taxes on income earned in accordance with its tax-exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the financial statements.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the State of New Hampshire (the State) and the Center for Disease Control, the Organization took steps to create safe distances between both staff and patients. All providers received the necessary equipment to allow for medical and behavioral health visits using telehealth.

The Organization received a loan in the amount of $645,100 in April 2020 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act. The PPP is subject to forgiveness, upon the Organization's request, to the extent that the proceeds are used to pay qualifying expenditures, including payroll costs, rent and utilities, incurred by the Organization during a specific covered period. The Organization is following the conditional contribution model to account for the PPP and determined the conditions for forgiveness were substantially met during the year ended September 30, 2020. The Organization was notified in November 2020 the PPP loan was fully forgiven by the SBA and the lender.

The CARES Act and the PPPHCE Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services (HHS). The Organization received PRF in the amount of $592,593 during the year ended September 30, 2020. Management believes the Organization incurred qualifying expenditures of $502,578 and $90,015 during the years ended September 30, 2021 and 2020, respectively, and recorded grant revenue equal to the qualifying expenditures. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, the amount of income allowed to be recognized may change. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

During May 2020, the Organization received a loan in the amount of $250,000 from the COVID-19 Emergency Healthcare System Relief Fund (Relief Loan), a program implemented by the State, Department of Health and Human Services and available for use through December 30, 2020. The Relief Loan had the potential to be converted to a grant at the sole discretion of the State. The Relief Loan was converted to a grant on October 26, 2020 and recognized as revenue at that time.

Cash and Cash Equivalents and Certificates of Deposit

Cash and cash equivalents consist of business checking and savings accounts, certificates of deposit with an original maturity of three months or less and petty cash funds. Certificates of deposit are set to autorenew for the same term upon maturity. Those with original maturity dates greater than three months but less than twelve months are reported as short-term and those with original maturity dates greater than twelve months are reported as long-term.

The Organization maintains cash and certificate of deposit balances at several financial institutions. The balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000. At various times throughout the year, the Organization's balances may exceed FDIC insurance. The Organization has not experienced any losses in such accounts and management believes it is not exposed to any significant risk.

Revenue Recognition and Patient Accounts Receivable

During the year ended September 30, 2021, the Organization has adopted Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance, which supersedes accounting standards that previously existed under U.S. GAAP and provides a single revenue model to address revenue recognition to be applied by all companies. Under the new standard, organizations recognize revenue when a customer obtains control of promised goods or services in an amount that reflects the consideration to which the organization expects to be entitled in exchange for those goods and services. Topic 606 also requires organizations to disclose additional information, including the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The Organization elected to adopt this ASU retrospectively with the cumulative effect recognized at the date of initial application; therefore, the financial statements and related notes have been presented accordingly.

The adoption of Topic 606 had no impact on the Organization's net assets, results of its operations, or cash flows. The adoption of Topic 606 did change how implicit price concessions are presented in the financial statements. Under the previous standards, the estimate for amounts not expected to be collected based upon historical experience was reflected as a provision for doubtful accounts, and presented separately as an offset to net patient service revenue. Under the new standards, the estimate for amounts not expected to be collected based on historical experience continues to be recognized as a reduction to net revenue, but not reflected separately as provision for doubtful accounts.

The impact of the adoption on the statement of operations for the year ended September 30, 2020 was as follows:

	As Originally Reported	Adjustments due to Topic 606 Adoption	Revised Balance
Patient service revenue	$ 4,612,434	$ (156,485)	$ 4,455,949
Provision for bad debts	(156,485)	156,485	-
Net patient service revenue	$ 4,455,949	$ -	$ 4,455,949

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payers (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Organization. The Organization measures the performance obligation for medical, behavioral health and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Organization measures the performance obligation for contract pharmacy services based on when the prescription is dispensed to the patient. The Organization's performance obligations are satisfied at a point in time.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Organization's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience.

Consistent with the Organization's mission and FQHC designation, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Organization expects to collect based on its collection history with those patients.

The Organization has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payer. In assessing collectability, the Organization has elected the portfolio approach. The portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers (patients). The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payer or group of payers will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. Payer concentrations are disclosed in Note 7.

The Organization bills the patients and third-party payers several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Organization is primarily reimbursed for medical, behavioral health and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other services are reimbursed based on fee-for-service rate schedules.

Medicaid

The Organization is primarily reimbursed for medical, behavioral health and ancillary services based on prospectively set rates for an encounter furnished to a Medicaid beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other services are reimbursed based on fee-for-service rate schedules.

Other Payers

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Organization is reimbursed for services based on contractually obligated payment rates for each Current Procedural Terminology code, which may be less than the Organization's public fee schedule.

Patients

The Organization provides care to patients who meet certain criteria under its sliding fee discount policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization sliding fee discount policy amounted to $50,507 and $151,882 for the years ended September 30, 2021 and 2020, respectively. The Organization is able to provide these services with a component of funds received through local community support and federal grants.

For uninsured patients who do not qualify under the Organization's sliding fee discount program, the Organization bills the patient based on the Organization's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

340B Contract Pharmacy Program Revenue

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. This program requires drug manufacturers to provide outpatient drugs to FQHCs and other covered entities at a reduced price. The Organization contracts with local pharmacies under this program. The contract pharmacies dispense drugs to eligible patients of the Organization and bill commercial insurances on behalf of the Organization. Reimbursement received by the contract pharmacies is remitted to the Organization, less dispensing and administrative fees. The dispensing and administrative fees are costs of the program and not deemed to be implicit price concessions which would reduce the transaction price.

Laws and regulations governing the Medicare, Medicaid and 340B programs are complex and subject to interpretation. Management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare, Medicaid, and 340B programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances and consisted of the following at September 30:

	2021	2020
Medical and dental patient accounts receivable	$ 548,279	$ 615,721
Contract 340B pharmacy program receivables	188,313	56,897
Total patient accounts receivable	$ 736,592	$ 672,618

Accounts receivable at October 1, 2019 were $625,349.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. The accounts receivable from patients and third-party payers, net of allowances, were as follows at September 30:

	2021	2020
Governmental plans		
Medicare	27 %	29 %
Medicaid	39 %	44 %
Commercial payers	19 %	14 %
Patient	15 %	13 %
Total	100 %	100 %

Grants Receivable

Grants receivable are stated at the amount management expects to collect from outstanding balances. All such amounts are considered collectible.

The Organization receives a significant amount of grants from HHS. As with all government funding, these grants are subject to reduction or termination in future years. For the years ended September 30, 2021 and 2020, grants from HHS (including both direct awards and awards passed through other organizations) represented approximately 90% and 78%, respectively, of grants, contracts and contributions revenue.

A portion of the Organization's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Organization has met the performance requirements or incurred expenditures in compliance with specific contract or grant provisions, as applicable. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue.

The Organization has been awarded cost reimbursable grants that have not been recognized at September 30, 2021 because qualifying expenditures have not yet been incurred as follows:

	Amount	Available Through
Health Center Program	$ 942,733	February 28, 2022
Integrated Behavioral Health Services	83,500	February 28, 2022
American Rescue Plan Act Funding for Health Centers	1,306,625	March 31, 2023
Total grant funds available	$ 2,332,858	

The Organization also received a capital grant, *Health Center Infrastructure Support*, in the amount of $555,649 which is available for use for approved capital projects through September 14, 2024. The Organization intends to use this grant for the renovation of the Organization's Laconia, New Hampshire facility. See Note 4 for further discussion regarding the project.

Assets Limited as to Use

Assets limited as to use include cash and cash equivalents set aside under loan agreements for repairs and maintenance on the real property collateralizing the loan, and assets designated by the Board of Directors for specific projects or purposes as discussed further in Note 3.

Property and Equipment

Property and equipment are carried at cost. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. The Organization's capitalization policy is applicable for acquisitions greater than $5,000.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations as net assets released from restriction. Contributions whose restrictions are met in the same period as the support was received are recognized as net assets without donor restrictions.

Donated Pharmaceuticals

The Organization acts as a conduit for pharmaceutical company patient assistance programs. The Organization provides assistance to patients in applying for and distributing prescription drugs under the programs. The value of the prescription drugs distributed by the Organization to patients is not reflected in the accompanying financial statements. The Organization estimates that the value of prescription drugs distributed by the Organization for the years ended September 30, 2021 and 2020 was $159,922 and $225,634, respectively.

Functional Expenses

The financial statements report certain categories of expenses that are attributable to more than one program or supporting function; therefore, these expenses require allocation on a reasonable basis that is consistently applied. As the Organization is a service organization, such expenses, which include employee benefits, occupancy, depreciation, interest, and other operating expenses, are allocated between healthcare services and administrative support based on the percentage of direct care wages to total wages.

Excess of Revenue Over Expenses

The statements of operations reflect the excess of revenue over expenses. Changes in net assets without donor restrictions which are excluded from this measure include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through January 12, 2022, the date that the financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

2. Availability and Liquidity of Financial Assets

The Organization regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents and certificates of deposit.

The Organization had working capital of $3,605,990 and $2,518,840 at September 30, 2021 and 2020, respectively. The Organization had average days cash and cash equivalents and certificates of deposit on hand (based on normal expenditures) of 192 and 175 at September 30, 2021 and 2020, respectively.

Financial assets available for general expenditure within one year were as follows at September 30:

	2021	2020
Cash and cash equivalents	$ 2,946,398	$ 2,135,630
Short-term certificates of deposit	935,086	933,483
Patient accounts receivable, net	736,592	672,618
Grants receivable	113,256	275,519
Financial assets available	$ 4,731,332	$ 4,017,250

The Organization has certain board-designated assets limited to use which are available for general expenditure within one year in the normal course of operations upon obtaining approval from the Board of Directors. The Organization has other assets limited to use under certain loan agreements which are available for general expenditure within one year for maintenance and repairs on the Organization's buildings upon obtaining approval from the lenders. Accordingly, these assets have not been included in the qualitative information above.

The Organization's goal is generally to have, at the minimum, the Health Resources and Services Administration recommended days cash and cash equivalents on hand for operations of 30 days.

3. Assets Limited as to Use

Assets limited as to use are made up of cash and cash equivalents which are to be used for the following purposes at September 30:

	2021	2020
Repairs and maintenance on the real property collateralizing loans with the United States Department of Agriculture, Rural Development (Rural Development)	$ 105,429	$ 103,768
Board-designated for		
Working capital	40,000	40,000
Capital improvements	49,761	42,403
Total board-designated	89,761	82,403
Total	$ 195,190	$ 186,171

4. Property and Equipment

Property and equipment consisted of the following at September 30:

	2021	2020
Land	$ 109,217	$ 109,217
Building and improvements	2,136,441	2,136,441
Furniture and equipment	179,772	169,040
Total cost	2,425,430	2,414,698
Less accumulated depreciation	882,729	816,499
	1,542,701	1,598,199
Construction in progress	64,239	-
Property and equipment, net	$ 1,606,940	$ 1,598,199

The construction in progress primarily relates to the redesign and re-construction of the Laconia, New Hampshire facility entrance way, patient reception and waiting room to create a safe and effective flow for patients so as to minimize patient to patient contact and the possible spread of COVID-19. The total project cost is estimated at $750,000 and anticipated to be wholly funded by capital grants. The renovation is projected to be completed by October 2022.

Property and equipment acquired with Federal grant funds are subject to specific federal standards for sales and other dispositions. In many cases, the Federal government retains a residual ownership interest in the assets, requiring prior approval and restrictions on disposition.

5. Long-Term Debt

Long-term debt consists of the following at September 30:

	2021	2020
4.125% promissory note payable to Rural Development through March 2037, paid in monthly installments of $8,186, including interest. The note is collateralized by all tangible property owned by the Organization.	$ 1,121,668	$ 1,172,471
3.375% promissory note payable to Rural Development, through May 2052, paid in monthly installments of $1,384, including interest. The note is collateralized by all tangible property owned by the Organization.	316,161	321,992
Total	1,437,829	1,494,463
Less current portion	60,162	57,826
Long-term debt, less current portion	$ 1,377,667	$ 1,436,637

Maturities of long-term debt are as follows at September 30:

2022	$ 60,162
2023	61,609
2024	64,146
2025	66,788
2026	69,540
Thereafter	1,115,584
Total	$ 1,437,829

6. Net Assets

Net assets without donor restrictions are designated for the following purposes at September 30:

	2021	2020
Undesignated	$ 3,997,434	$ 2,840,012
Board-designated (see Note 3)	89,761	82,403
Total	$ 4,087,195	$ 2,922,415

7. Patient Service Revenue

Patient service revenue was as follows for the years ended September 30:

	2021	2020
Gross charges	$ 5,786,824	$ 5,099,034
Less: Contractual adjustments and implicit price concessions	(1,872,977)	(1,644,279)
Sliding fee scale discounts	(42,446)	(126,548)
Medical and dental patient service revenue	3,871,401	3,328,207
340B contract pharmacy revenue	1,437,554	1,127,742
Total patient service revenue	$ 5,308,955	$ 4,455,949

Revenue from patients and third-party payers, net of allowances and adjustments, was as follows for the years ended September 30:

	2021	2020
Governmental plans		
Medicare	16 %	14 %
Medicaid	63 %	66 %
Commercial payers	18 %	17 %
Patient	3 %	3 %
Total	100 %	100 %

8. Retirement Plan

The Organization has a defined contribution plan covering eligible employees. The Organization contributed $101,154 and $80,976 for the years ended September 30, 2021 and 2020, respectively.

9. Malpractice

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of September 30, 2021, there were no known malpractice claims outstanding which, in the opinion of management, will be settled for amounts in excess of either FTCA or medical malpractice insurance coverage, nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

10. Litigation

From time-to-time certain complaints are filed against the Organization in the ordinary course of business. Management vigorously defends the Organization's actions in those cases and utilizes insurance to cover material losses. In the opinion of management, there are no matters that will materially affect the Organization's financial statements.

SUPPLEMENTARY INFORMATION

HEALTHFIRST FAMILY CARE CENTER, INC.

Schedule of Expenditures of Federal Awards

Year Ended September 30, 2021

Federal Grantor/Pass-Through Grantor Program Title	Assistance Listing Number	Pass-Through Contract Number	Total Federal Expenditures
U.S. Department of Health and Human Services			
Direct			
Health Center Program Cluster			
Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		$ 438,159
COVID-19 Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		643,221
Total AL 93.224			1,081,380
Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program	93.527		970,140
Total Health Center Program Cluster			2,051,520
COVID-19 Provider Relief Fund	93.498		592,593
Pass-Through			
State of New Hampshire Department of Health and Human Services			
COVID-19 Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)	93.323	05-95-90-903010-19010000	193,330
Cancer Prevention and Control Programs for State, Territorial and Tribal Organizations	93.898	102-500731/90080081	9,161
Maternal and Child Health Services Block Grant to the States	93.994	102-500731/90080000	61,616
Total U.S. Department of Health and Human Services			2,908,220
U.S. Department of Treasury			
Pass-Through			
State of New Hampshire Department of Health and Human Services			
COVID-19 Coronavirus Relief Fund	21.019	n/a	250,000
COVID-19 Coronavirus Relief Fund	21.019	158221	96,670
Total AL 21.019			346,670
U.S. Federal Communications Commission			
Pass-Through			
Community Health Access Network			
COVID-19 Telehealth Program	32.006	n/a	34,178
Total Expenditures of Federal Awards			$ 3,289,068

The accompanying notes are an integral part of this schedule.

HEALTHFIRST FAMILY CARE CENTER, INC.

Notes to Schedule of Expenditures of Federal Awards

Year Ended September 30, 2021

1. Summary of Significant Accounting Policies

Expenditures reported on the schedule of expenditures of federal awards (the Schedule) are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), wherein certain types of expenditures are not allowable or are limited as to reimbursement.

2. De Minimis Indirect Cost Rate

HealthFirst Family Care Center, Inc. (the Organization) has elected not to use the 10% de minimis indirect cost rate allowed under the Uniform Guidance.

3. Basis of Presentation

The Schedule includes the federal grant activity of the Organization. The information in this Schedule is presented in accordance with the requirements of the Uniform Guidance. Because the Schedule presents only a selected portion of the operations of the Organization, it is not intended to and does not present the financial position, changes in net assets, or cash flows of the Organization.

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INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
HealthFirst Family Care Center, Inc.

We have audited, in accordance with U.S. generally accepted auditing standards and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of HealthFirst Family Care Center, Inc. (the Organization), which comprise the balance sheet as of September 30, 2021, and the related statements of operations and changes in net assets, functional expenses and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated January 12, 2022.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Organization's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Board of Directors
HealthFirst Family Care Center, Inc.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Organization's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
January 12, 2022

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE FOR THE MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

Board of Directors
HealthFirst Family Care Center, Inc.

Report on Compliance for the Major Federal Program

We have audited HealthFirst Family Care Center, Inc.'s (the Organization) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on its major federal program for the year ended September 30, 2021. The Organization's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for the Organization's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with U.S. generally accepted auditing standards; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Organization's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of the Organization's compliance.

Opinion on the Major Federal Program

In our opinion, HealthFirst Family Care Center, Inc. complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended September 30, 2021.

Report on Internal Control Over Compliance

Management of the Organization is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Organization's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
January 12, 2022

HEALTHFIRST FAMILY CARE CENTER, INC.

Schedule of Findings and Questioned Costs

Year Ended September 30, 2021

1. Summary of Auditor's Results

Financial Statements

Type of auditor's report issued:		Unmodified		
Internal control over financial reporting:				
Material weakness(es) identified?	☐	Yes	☑	No
Significant deficiency(ies) identified that are not considered to be material weakness(es)?	☐	Yes	☑	None reported
Noncompliance material to financial statements noted?	☐	Yes	☑	No

Federal Awards

Internal control over major programs:				
Material weakness(es) identified?	☐	Yes	☑	No
Significant deficiency(ies) identified that are not considered to be material weakness(es)?	☐	Yes	☑	None reported
Type of auditor's report issued on compliance for major programs:		Unmodified		
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	☐	Yes	☑	No

Identification of major programs:

Assistance Listing Number	Name of Federal Program or Cluster
	Health Center Program Cluster

Dollar threshold used to distinguish between Type A and Type B programs:		$750,000		
Auditee qualified as low-risk auditee?	☑	Yes	☐	No

2. Financial Statement Findings

None

3. Federal Award Findings and Questioned Costs

None

Board of Directors

James Wells
Christine Merriman
Michael Stanley
Susan Wnuk
Susan Lunt
Bill Purslow
Michelle Lennon
Scott Burns
Myla Everett
Robert St Jacques Sr.
Dawn Sanchez
Leroy Hollis
Kandyce Tucker

AUDREY GOUDIE

PROFESSIONAL SUMMARY

Driven communications professional with a demonstrated record of accomplishment and passion serving non-profit organizations for nearly three decades. A natural leader and hands-on strategist skilled in building relationships with stakeholders and developing/managing complex projects, programs, and events. Accomplished Executive Director seeking a challenging role where I can utilize my creative thinking, outstanding communication and networking skills to develop and grow partnerships, systems, and programs that produce impactful change and life improvements for individuals of all ages.

WORK HISTORY & ACCOMPLISHMENTS

Director of Marketing, Communication, and Philanthropy, July 2020 - present
HealthFirst Family Care Center

- Responsible for all marketing and communication activities as it relates to the promotion of the health center's programs, services, providers, and activities utilizing a variety of media outlets including print, radio, social media, target marketing, video, and more.
- Develop and oversee the health center's strategic philanthropy initiatives including fundraising activities to support programming, special events, annual appeals, capital campaigns, grant writing and reporting, and more.
- Experienced grant writer with successful track record securing federal and state grants and loans.
- Serve as a member of the Leadership Team who is responsible for effectively leading the organization by example and ensuring that decision-making is in alignment with the organization's strategic goals.

Executive Director, 2016 to 2020
Community Health Services Network, LLC

- Directed an Integrated Delivery Network (IDN) comprised of 31 healthcare and social service agencies via a Medicaid 1115 waiver providing innovative programs and strategies to transform the delivery of care and improve health outcomes for participants faced with mental health and/or substance use disorders.
- Effective leader and team member willing to stray from the norm to find creative solutions for best outcomes.
- Managed and directed all fiscal operations, including oversight of a $15M budget, authorizing expenditures, reimbursements, grant tracking, accounting and coordinating financial reporting.
- Served on statewide task forces and workforce initiatives to help develop sustainability plans, design Alternative Payment Models, and affect policy change pertaining to licensing and reciprocity laws.
- Assisted partners with the tools needed to collect agency specific outcome and performance data required for DHHS reporting and receipt of continued incentive payments.
- Provided oversight of six project workgroups by providing leadership, guidance and technical assistance needed to support teams in meeting project deadlines and goals. Workgroups include HIT, Integrated Health, Workforce, Supportive Community Re-Entry, Expansion in Intensive Outpatient Treatment and Enhanced Care Coordination for High Needs Population. Each project has a specific focus of integrating one's behavioral health needs within their primary care, identifying the social determinants of health and connecting to appropriate social services.
- Advocated coalition building and breaking down silos to move partners closer to an integrated model of care.
- Strong communicator and public speaker who always identifies community engagement and education opportunities while remaining mindful of Board priorities and opportunities.
- Authored numerous high quality DHHS and CMS reports required to demonstrate program outcomes and progress toward goals. Each report resulted in receiving future incentive payments and was complimented by DHHS staff on the submission of "impeccable reports."
- Served as the face and voice of the IDN for all State, County or media activities. Served as the communications hub and liaison for partners while working closely with organizational leadership, board of directors, network partners and staff to strategically move and affect project outcomes.

- Proven history of designing and developing unique solutions. For example, to support partner engagement, program knowledge and deadline compliance, a creative team-based solution was developed (Employee Retention Incentive Program) which resulted in enhanced workforce satisfaction and retention.
- Continuously sought to grow my own knowledge, skills and performance based on feedback sought from peers, Board members, stakeholders and self-identified professional developmental needs.
- Achieved high staff morale and retention through effective communication, transparency, prompt problem resolution, finding creative solutions and implementing proactive supervisory practices all while keeping work fun.

Executive Director & Community Relations Administrator, NH Electric Co-op Foundation 2010 to 2016
Marketing & Sales Administrator, NH Electric Cooperative, Inc. 2000 to 2010

- Developed and nurtured relationships with businesses and community members through various networking opportunities and events to foster good will within the communities served. Represented the organization at community events, served on area boards, developed civic programs, engaged in community service, volunteered and grew organizational alliances.
- Met strategic and cultural goals by developing and maintaining effective working relationships with co-workers and stakeholders by being innovative and results-oriented while exhibiting self-leadership and always seeking feedback.
- Provided guidance to charitable organizations applying for grants and served as the liaison making funding recommendations to the Board.
- Awarded nearly $250,000 annually to non-profit organizations applying for funding.
- Increased monthly revenue stream by $20k available for grant funding (via the Round Up program) in three years' time through promotion and outreach.
- Sought innovative ways to grow the Foundation's fund balance to ensure it would continue to meet its charitable purpose for years to come via investment of funds and fundraising campaigns.
- Developed two scholarship programs serving 15 high school students and one adult learner annually.
- Created a half a million-dollar fundraising campaign in four months to benefit the NH Food Bank.
- Wrote policies and procedures, bylaws, press releases, annual reports, managed the NHEC Foundation budget and ensured compliance with Federal, State and local regulations.
- As Marketing & Sales Administrator, I developed and implemented strategic marketing plans and sales efforts for the Energy Solutions Division overseeing three statewide energy efficiency programs that consistently achieved and/or exceeded program goals, serving thousands of members annually while reducing the inefficient use of energy.

Director, Community Relations, 1997 to 2000; **Clinic & Physician Services Manager,** 1994 to 1997
Littleton Regional Hospital

- Developed, managed and marketed all internal and external community relations activities via newsprint, television, campaigns, brochures, press events, etc.
- Managed and grew the hospital's Junior and Senior Volunteer Program of 100+ individuals.
- Established public interest, understanding and good will towards the hospital by organizing and offering programs and events to and for the local community. Served as event planner and manager for numerous annual fundraising events which include: Women's Health Conference, LRH-LMC Tennis Tournament, LRH Golf Extravaganza, North of the Notch Bone Marrow Donor Drive; 55 Alive Mature Driving Course; Bridge-to-Wellness program for senior citizens; Parent & Childcare Provider Conference; North Country Shaken Baby Syndrome Conference, etc.
- Supervised the hospital's first regional community market needs assessment.
- Reported directly to the CEO and worked collaboratively with the senior management team, Board of Trustees, employees and medical staff in an integrated fashion to ensure the hospital's organizational strategies and goals were met.
- As Clinic and Physician Services Manager, I was responsible for initial start-up and management of two off-site family health centers/physician practices. Activities included marketing, hiring, training, office set up, managing practice budgets, credentialing of physicians and allied health professionals and ensured compliance with Joint Commission on Accreditation of Health Care Organizations (JCAHO), NH State law and hospital bylaws.

EDUCATION

Master of Public Administration – Currently enrolled - University of New Hampshire, Durham, NH
Bachelor of Arts in Communications, 1990 - University of Southern Maine, Portland, ME

SKILLS/ACHIEVEMENTS/BOARDS

- Graduate, Bi-State Primary Care Association's Leadership Development Program 2020/2021
- DSRIP Learning Collaborative Advisory Panel, 2018 - 2021
- Board Advisory Committee, Navigating Recovery of the Lakes Region, 2018-2020
- Board Member/Secretary, Mid-State Health Center, 2016-2020
- Graduate, University of New Hampshire's Economic Development Academy, 2015
- Graduate, Central NH Leadership Academy, 2014
- Board Member, Greater Meredith Program, 2012-2015
- President/Co-founder, Newfound Area Charitable Fund, 2011-present
- Co-Race Director, Run Your Buns Off 4.2 Mile Road race, 2010-present
- Owner/Operator & ACE Certified Personal Trainer, NH Adventure Boot Camp for Women, 2006 to 2016
- Executive Director/Board Member, Lakes Region Builders & Remodeler's Association, 2004-2008
- Vice-president, Lisbon Regional High School Alumni Committee, 1998-2005
- Board Member, Littleton Area Chamber of Commerce, 1997-2000

STACEY BENOIT

Dedicated Practice Manager for 24 years combining experience in management and patient service experience in the healthcare setting. I am driven by providing exceptional service to patients and their families.

SKILLS

- Active Listening
- Judgement and Decision Making
- Social Perceptiveness
- Critical Thinking
- Service Orientation
- Learning Strategies
- Financial Management
- Coordination
- Troubleshooting
- Communication
- Project Management

EXPERIENCE

Practice Manager Oct. 2017- current
HealthFirst Family Care Center

- Coordinate and facilitate team and provider meetings, and special events.
- Compose, type and distribute meeting notes, routine correspondence, reports, such as presentations, statistical or monthly reports.
- Review work to ensure quality material and information is in place and that company policies are followed.
- Manage projects as determined by the CEO.
- Develop training and onboarding tools to assist staff with meeting performance expectations.
- Maintain provider schedules and ensure productivity goals are met. Discuss issues or ideas with CEO.
- Recruit, hire and onboard new administrative staff as needed.
- Ensure customer service standards are met and address customer complaints promptly.
- Attend monthly management team meetings.

Practice Manager Jan. 1994 - Oct. 2017
Concord Orthopaedics Concord, NH

- Perform payroll functions, such as maintaining timekeeping information and processing and submitting payroll.
- Recruit, hire and onboard staff for clinical, patient services, radiology and leadership positions.
- Project Manager for the Patient Experience Committee, includes marketing efforts for new services lines.
- Use various computer applications, such as Microsoft programs, PowerPoint, Word & Excel, electronic health records and practice management software.
- Set up and manage paper and electronic filing systems, updating paperwork, or maintaining documents, such as credentialing, business associate agreements and other correspondences.

• Operate office equipment, such as fax machines, copiers and phone systems and arrange for repairs and upgrades as needed.
• Maintain and oversee schedules for 39 Providers. Ensuring patients have appropriate access to care. .
• Responsible for efficient and cost-effective planning of all patient care, clinical and radiology staff.
• Coordinate and facilitate team meetings, and special events, such as "luncheon learns".
• Compose, type and distribute meeting notes, routine correspondence, reports, such as presentations, statistical or monthly reports.
• Review work to ensure quality material is in place and that company policies are followed.
• Manage projects as determined by the Practice Administrator or CEO.
• Work with Leadership to develop training and onboarding tools to assist staff with meeting performance expectations.
• Oversee and ensure corporate compliance with Meaningful Use and Clinical Quality Compliance programs.

Chiropractic Assistant June 1991- Dec 1994
Interlakes Chiropractic Center Meredith, NH
• Answer telephones and give information to callers, take messages, or transfer calls to appropriate individuals.
• Collect co-payments and enter money into accounts, daily balancing of funds collected, prepare bank deposits.
• Assist patients with financial counseling process when appropriate.
• Create, maintain, and entered patient demographics and insurance information into databases.
• Set up and manage paper or electronic filing systems, recording information, updating paperwork or maintaining documents, such as patient progress notes, correspondence, or other material.
• Operate office equipment, such as fax machines, copiers and phones systems.
• Greet visitors or callers and handle their inquiries or direct them to the appropriate person for assistance.
• Maintain physician's schedules.
• Schedule and confirm appointments for patients.
• Make copies of correspondence or other printed material.
• Maintain patient health record information according to office policy.
• Prepare patients for their appointment with the physician, such as, collect chief complaint, change attire, apply modalities as appropriate.
• Provided patient education material as directed by the physician.
• Other duties as assigned.

EDUCATION

Associates of Applied Science: Business Management June 1991
Lakes Region Community College - Laconia, NH

Ted Bolognani

Professional Summary

- Solid background in senior management with strong emphasis in finance, budget, financial planning & forecasting, GL fund accounting, audit, benefit & risk insurance and technology implementation.
- Proven record of building strong operational & financial support systems for tuition based academic programs and federally funded grant programs.
- Strong knowledge of federal rules & regulations including OMB circulars, CDC, USAID and FAR & FASB compliance issues as well as A-133 audit requirements.
- Skilled in developing and implementing standardized operating policies and procedures for all aspects of administration, accounting, grants & sub-awarding as well as overseas financial operations.
- Over 10 years experience working internationally in Africa, Asia & Eastern Europe.

Experience

Health First Family Care Center & Caring Community Network of Twin Rivers (CCNTR)
Job Title: **Chief Financial Officer** 2011 - Present

- Responsibility for the integrity of the financial records and monitoring the daily business operations; duties include maintenance of the general ledger, accounts payable, accounts receivable, payroll and fixed assets.
- Prepare trial balance and financial statements and reports to the Board of Directors on the financial condition of the Center.
- Provide financial analysis data to CEO and monitors the annual budget and grants. The CFO tracks, bills and prepares the financial reporting on each of the grants.
- Develop policy & procedures for improving grant management & accounting operations.

World Learning 2008 - 2011
Job Title: **Director of Finance**

- Direct a team of analyst; lead organization wide process such as budget development ($120M annual, $60M federal grant), financial planning, quantitative analysis, multi-year forecasting and business & reporting systems.
- Develop policy & procedures for improving company administrative & accounting operations and international project management.
- Manage treasury operations, international banking, foreign exchange hedging and investment portfolio.
- Oversight on federal indirect cost control issues, granting & contracting processes and project compliance.
- Liaise with Board & business partners on investment, budget and reporting.
- Manage implementation of process improvements and tech systems include budget & reporting software, field accounting, HR & payroll information systems and web based technology for management data.

The American Youth Foundation 2005 - 2008
Job Title: **Director of Finance**

- Directed the student registrar office, accounting, human resources, audit, risk insurance and administrative functions for 3 locations (MO, MI & NH).
- Directed the information technology (IT) services for company's 3 office network, including installation of new email and communication systems and moving financial systems to web platform & Citrix desktop.
- As senior management, participated in strategic planning, policy formation and major decision making with CEO & Board of Directors.
- Served foundations Board on all financial, audit & investment matters.

Ashley Douthart

Skills

- Individual counseling of all ages (3-65+)
- School based counseling
- Mental Health Illness
- Cognitive Behavioral Therapy
- Children and Adolescents
- Leadership skills
- DSM-V/ICD-10
- Prenatal counseling
- Substance use counseling
- Behavioral Modification
- Mindfulness
- Medication Assisted Treatment
- Community engagement

Experience

NOV 2014 – CURRENT
Behavioral Health Manager, LCMHC / HealthFirst, Franklin NH
Roles at HealthFirst include all above listed skills, as well as managing/supervising interns and the internship program, managing the school based counseling program for local school districts in the community, and providing a variety of therapeutic interventions to individual clients both in schools and in office. Responsible for managing the behavioral health team, in all HealthFirst locations. Responsible for behavioral health grants, hiring new staff, managing staff, schedules, and completing any reporting requirements. Manages caseload of approximately sixty patients of all ages and mental health diagnoses. Facilitates team meetings, attends all leadership meetings, and engages in community meetings and projects.

SEPT 2011 – JULY 2014
ABA Therapist/Socialization Coordinator / Autism Intervention Specialist, Worcester MA
Supervisory role in behavioral modification with children with ASD. I provided both in office and in home Applied Behavioral Analysis therapy to parents and children.

Education

AUG 2014
MS Clinical Mental Health Counseling / Walden University
Graduating GPA 3.9/Honors student

Internship Dec 13'-July 14' HealthFirst Family Care Center, [redacted]

MAY 2010
BA Psychology / Colby Sawyer College, New London NH
Minor: Child Development/Graduating GPA 3.7/ Psi Chi International Honor Society Member

Internship Jan 2010-May 2010 CHAD Child Advocacy Center

Activities

- CERT (Community Emergency Response Team) Member 2015-current
- DBHRT (Disaster Behavioral Health Response Team) Member 2017-current
- CPR/First Aid Certified
- Systems of Care Community Management Team- 2017-current
- Project Aware Community Management Team- 2017-current
- Principal Investigator for Plymouth State University Intern Program/Site Supervisor- 2019-current
- Member of the Plymouth State University Advisory Board for Graduate Counseling Program- 2021
- Approved Licensed Clinical Supervisor through Board of Mental Health, State of NH- 2020-current
- MLADC supervision- currently engaging in, with proposed finish date of October 2022

Melissa Fisk, PHR, SHRM-CP

PROFESSIONAL SUMMARY

Performance-driven, innovative Human Resources Leader with 10 + years of progressive, diversified, and strategic HR leadership experience across small and large multi-state organizations. Established critical partner experienced in all facets of HR including designing, planning, and implementing solutions, programs, and policies in the areas of company culture, benefits, compensation, recruitment, employee relations, compliance, performance management, and risk management.

EDUCATION

Bishop's University, Sherbrooke, Quebec Canada
Bachelor's Degree, Business Administration

CERTIFICATIONS

Professional in Human Resources (PHR) - HR Certification Institute
Certified Professional (SHRM- CP) - Society for Human Resource Management

EXPERIENCE

Human Resources Director June 2020 - Present
HealthFirst Family Care Center, Inc.
HR Leader responsible for developing and executing human resource strategy in support of the overall business plan and strategic direction of the health center.

- Leads the development and maintenance of a desirable, consistent, and prominent culture across the organization. Plays a lead role in structuring, supporting, and partnering with all levels to ensure the workforce and culture are aligned with HealthFirst's needs, strategy, and budget.
- Identifies, retains, and develops high performing employees who are a cultural fit or adapt to HealthFirst's culture. Ensures HealthFirst remains agile in a competitive labor market and helps proactively guide culture changes. Reduces costly turnover by facilitating a positive, communicative, engaged work environment and competitive total compensation packages.
- Ensures operational efficiency in workforce planning by identifying appropriate staffing utilization and minimizing the need for overtime. Assists in managing paid time off liability and work/life balance by encouraging appropriate time off usage.
- Leads recruitment and hiring efforts for all staff, including providers, to ensure a superior workforce. Builds and cultivates a pipeline of the best talent available, positioning HealthFirst as an employer of choice.
- Provides HR-based education and training to department heads such as supervisory responsibilities, Federal and State laws/regulations, performance reviews, organizational policies and procedures.
- Facilitates mediation for conflict management and problem-solving dialogues. Provides performance management guidance (coaching, counseling, career development, disciplinary actions).
- Develops and implements compensation and benefits strategies. Gathers annual market data regarding salaries, benefits, and compensation methods. Recommends market pay adjustments, incentive compensation systems, and other pay and benefits changes and enhancements.
- Ensures appropriate accountability and high performing teams by working with managers to ensure ever-improving accountability structures. Works together with managers on establishment or revision of annual goals, tracking of performance, ongoing coaching and feedback for employees, active approaches for disengaging with poor performers, and other best practices associated with managing performance to achieve a high performing organization.
- Conducts workplace investigations and handles other sensitive and confidential matters with discretion and tact. Prepares appropriate write-ups and recommends resolutions working in conjunction with other senior leaders as needed.

Human Resources Manager September 2016 – June 2020
Concord Coach Lines, Dartmouth Coach, Boston Express Bus
HR Manager responsible for designing and implementing strategic HR initiatives while servicing 300+ employees across three states and three companies with common ownership.
• Researched and implemented Paylocity, an industry-leading, cloud-based, HCM software to simplify payroll performance and streamline HR tasks
• Researched and implemented ClearCompany, a Talent Success tool to unify recruiting, onboarding, performance management and goal tracking
• Utilize Predictive Index during hiring process for talent optimization and ensure alignment between business strategy and talent strategy
• Created Employee Handbook containing important policies, procedures and employee behavioral expectations to be distributed to new employees
• Partner with senior leaders and hiring managers to identify hiring requirements, craft effective job descriptions and manage end-to-end recruiting workflow to secure talent in a timely fashion
• Identified and utilized cost-effective billboards to enhance visibility for recruiting purposes
• Responsible for end-to-end talent acquisition and separation process including interviewing, reference checks and exit interview for term candidates
• Administer company-wide benefits including managing open enrollment and employee benefit presentations
• Manage RFP benefit process and negotiating with broker to establish cost-effective benefits program
• Manage multi-state New Hire Orientation including creating and presenting benefits information to new employees
• Responsible for all Employee Relations including investigations, performance management and management coaching
• Monitor Federal and State laws including, but not limited to, FMLA, LOA, STD, LTD and workers' compensation cases to guarantee compliance as required
• Supervise HR Assistant responsible for payroll, workers' compensation, recruiting for non-exempt positions

Human Resources Generalist December 2013 - September 2016
Praxair Surface Technologies, Inc.
Local HR Manager executing all generalist activities including benefits administration, recruiting, onboarding and employee relations for two facilities across two states serving 100+ employees.
• HR Manager supporting the acquisition of a North Carolina based competitor including onboarding of newly acquired employees to achieve employee engagement alignment to new company's goals and objectives
• Enhanced overall employee engagement by creating and managing focus groups and employment satisfaction surveys to direct organizational growth and benchmark data
• Established strategic onboarding process which included creating employee onboarding timeline, educating required safety protocols, identifying a lunch buddy and creating management training
• Responsible for interviewing for all positions and manage process using Taleo applicant tracking system Managed open enrollment and company-wide benefits program
• Coordinated payroll and benefits conversion to parent company
• Managed community engagement projects including Safety Commitment Day to educate on safety policies and procedures
• Implemented "build a bike program" encouraging employees to build bikes to be donated to the local Boys and Girls Club enhancing community service reputation
• Coordinated an employee mural painting project donated to a local hospital's children's wing

Eleanor (Nora) Janeway, M.D., M.Ed.

Education:

1983 B.A. Yale University, New Haven, CT
1986 M.Ed. Lesley College, Cambridge, MA
1993 M.D. University of California San Francisco School of Medicine

Postdoctoral Training, Residency:

1993-1996 Resident, Cambridge Hospital, Cambridge, MA
1996-1997 Chief Resident, Cambridge Hospital, Cambridge, MA

Primary-Care Internist, Community Health Centers

1994-1995 Internist, shelter for homeless patients with substance-use disorders
1994-2018 Windsor St. Health Center, immigrant and low-income patients
2018-present Medical Director, HealthFirst Family Care Center NH

Hospital Appointments:

1996-2018 Attending Physician, Cambridge Health Alliance

Academic Appointments:

1993-1996 Clinical Fellow in Medicine, Harvard Medical School
1996-2018 Clinical Instructor in Medicine, Harvard Medical School

Teaching, Supervisory and other work experience:

1985-1987 Classroom Teacher, Boston Public Schools, Grades 7/8
1987-1988 Worked in methadone program and as Hospice CNA
1996-present Taught and supervised Internal Medicine Residents
2004-2017 Taught Harvard Medical Students in clinical medicine
2015-present Clinical site director, CHA Residency Program, Windsor St.

Licensure, Certification and membership:

02/07/19-06/20/22: NH Medical License Registration
04/13/16-04/13/26: American Board of Internal Medicine Recertification
10/12/2017-present: Buprenorphine waiver for treatment of opioid addiction

Languages spoken:

Spanish, Bengali, Hindi.

Clinical Interests: Evidence-based Medicine, care of patients with dual diagnosis.

Russell G. Keene

A visionary, innovative, out of the box thinker who leads by example. A calming presence, influential, motivator, consensus builder, and results orientated.

President, Chief Executive Officer
HealthFirst Family Care Center, Inc. (FQHC) | Franklin, NH | 09-2019 - Present

- Leads the Board of Directors, Senior Management and community partners to create a shared vision of strategic goals for organizational improvement and growth, scope and quality of programs and services, resource development and allocation, and measurable impact on health status for targeted and community population groups.
- Proactively educates elected officials at the federal, state and local levels on issues that impact the mission of HealthFirst. Identifies areas for possible expansions and ways that the HealthFirst can better achieve its mission.
- Works strategically with the Chief Medical Officer (CMO) to develop and grow the medical services and position HealthFirst as a PCMH.
- Sets strategic direction for agency's short and long-term financial growth.
- Oversees, mentors and develops the Board of Directors, CFO and Staff in implementation of annual fundraising plan and Grant development. Develops substantial collaborative relationships with other organizations that can support the HealthFirst strategic goals.
- Oversees and mentors the Practice manager and Quality Coordinator on quality improvement and compliance; and marketing. Monitors effective organizational performance as it relates to all local, State, and Federal laws and regulations.
- Works strategically with the Human Resources (HR) Director to: create an agency culture that is centered on customer service, ensure that HealthFirst's most valuable asset is effectively used and supported and that all applicable laws and regulations are followed. Leads change management strategies and manages organizational change. Builds an effective and powerful management team; develops and leads the management team's growth and development.

Executive Manager State Opioid Response
Department of Health and Human Services| Concord, NH | 01-15-19 – 9-2019

- Provides strategic leadership and planning, programmatic oversight and operational direction for Federal and State funded initiatives ($60MIL grant) aimed at addressing the opioid crisis. Acts as official representative of the Department of Health and Human Services (DHHS) with internal and external stakeholders and key State leadership to identify opportunities and strategies for statewide coordination of opioid efforts that meet the State's long-range goals and priorities.
- Reviews, develops and implements current and future-funded Opioid Use Disorder (OUD) initiatives.
- Oversees and directs coordination among varied and multiple sources of Federal and State funds.
- Develops and maintains strong working relationships with executive-level leadership and agencies for the state including but not limited to the Governor's Office, Attorney General, Department Commissioners, and key legislative leadership.
- Leads, directs and supports collaboration with DHHS Divisions.
- Serves as the Commissioner's designee with other State agencies seeking to access Federal or State funds.
- Oversees the development of performance criteria and measures of success for OUD services.
- Advises and consults with staff on processes for grant applications, requests for proposals and contracting related to OUD services.
- Directs and monitors the collection and reporting of data and information related to SOR-funded initiatives to SAMHSA.

President, Chief Financial Officer
North Country Healthcare | Berlin, NH | 12-31-15 – 12-31-17

- **Dynamic results-oriented problem solver;** driving force and visionary behind the effort to design and implement an innovative multi-hospital system in rural Northern New Hampshire, increasing patient

access to comprehensive care with state of the art technology while saving multiple organizations millions of dollars. Established financial improvement plan and delivered positive operating margins at each institution.

- **Business strategist;** assisted in the development of a successful Accountable Care Organization (ACO) that achieved Medicare Shared Savings. This prepared the system for risk-based contracting.
- **Regulatory knowledge**; merged two large Home Health Agencies as authorized by State Attorney General.
- **Advanced senior leadership management**; successfully managed senior leaders to achieve strategic planning objectives. Developed a consensus as to strategic objectives and the associated tactical goals.
- **Versatile team member;** innate ability to adapt to any situation and contribute at any level. Distinct ability to lead, drive and hold team members accountable while facilitating an environment of teamwork and continuous improvement.
- **Operations Management;** diverse skill set with detailed understanding of HealthCare Operations and 22 years of experience
- **Customer focused;** participated in the development of new regional access for patients. Worked with the senior medical staff to develop a new call center to assist patients.
- **Articulate, confident speaker;** comfortable presenting to groups of any size. Possess the ability to delineate complex ideas to wide audiences and facilitate inclusive discussions.

Key Accomplishments

- **Visionary behind North Country Healthcare, a $7 Million savings in 18 months;** in rural New Hampshire, providing quality healthcare locally had become an extreme challenge over the last two decades. Attracting the best talent was equally challenging and having access to state of the art technology was fiscally impossible. A vision was developed to shape rural New Hampshire's healthcare for decades to come by allowing the four major hospitals in this distinct area to share resources, increase the buying and negotiating power of the organizations, and providing affordable best in class healthcare locally that can be sustained in the future. This success was the culmination of a two-year process and included convincing 4 previously competitive service areas to join forces in order to meet the challenges of a fluid healthcare environment. In addition, worked tirelessly with regulations to receive approval for the system to move forward.
- Participated in the development of a Regional Accountable Care Organization (ACO) that has created a decrease in costs of over $5M. This effort was successful due to the collaborative effort of each institution and concurrently mobilizing the medical staff(s) to understand common goals.
- Worked with State Legislative Branch to gain support for regulatory reimbursement enhancement. This effort entailed working with various legislators to clearly define further, the merits of our request. The result was ultimate stabilization of our Obstetrics Birthing (OB) programs in the North Country.
- Re-aligned Home Health operation to eliminate a $1.3M loss and achieve break-even status by hiring new leadership, instituting new cost controls, and, accelerating marketing efforts.

President, Chief Executive Officer
Androscoggin Valley Hospital | Berlin, NH | 06-01-02 – 12-31-15

- **Experienced Executive;** 13+ years of experience as Chief Executive Officer. Created financial stability in a highly challenging environment as the county we serviced is the most economically challenged and concurrently the sickest region in the entire state.
- **Leadership exemplified through relationships and communication;** obtained Critical Access Hospital (CAH) designation. This designation was an essential element of economic sustainability.
- **Diverse operational knowledge**; broad understanding of all hospital operations. Oversaw three separate Bond issues and the conversion of a Defined Benefit Plan to a Defined Contribution Plan. Bond issues were essential for facility improvements. Received an A- rating from Standard's Poors reflecting the collaborative networks which led to better healthcare for patients while also having a significant residual impact on recruiting top specialists.
- **Proponent of culture;** understands the importance of culture and adapting organizational goals and objectives. Worked to create commonality among the 500 employees.

- **Customer focused;** Partnered with tertiary facilities to expand clinical offerings to allow patients access to care previously only accessible at great distances. Successful in building new specialty lines to meet the demands and drive new revenue.
- **Confident decision maker;** comfortable making tough decisions based on experience and data. A broad understanding of HealthCare environment provides the ability to make decisions quickly and confidently. Ability to balance multiple, complex issues simultaneously.
- **Influential personality;** adept at building consensus. Influential and persuasive. Worked to establish a relationship with Legislative Branch that realized success with "special" programs for Androscoggin Valley Hospital.
- **Community Involvement;** in addition to strong leadership within the organization, also active in community endeavors. Elected to School Board and led the effort to examine budget and curriculum more closely.

Key Accomplishments

- Successfully converted to Critical Access Hospital resulting in revenue enhancements. Obtaining this special designation required convincing the Board, Medical Staff, and community that it would not result in reduced services.
- Achieved A- rating from Standard and Poors. This rating was indicative of the rating agencies favorable view of our fiscal integrity. By virtue of this positive rating, it benefitted the hospital in receiving lower interest rates.
- Delivered positive operating margins in a consistent manner. This was accomplished irrespective of AVH having one of the most difficult payor mixes in the State of NH (i.e., over 65% Medicare and Medicaid).
- Achieved significant facility upgrades through the Facility Master Plan. This effort was augmented by a capital campaign in the community.
- Saved over $10M in the conversion of Defined Benefit Plan. The savings were realized by taking advantage of Medicare reimbursement which subsidized the shortfall, i.e., the unfunded liability.

Vice President, Financial Services (CFO)
Androscoggin Valley Hospital | Berlin, NH | 03-15-95 – 05-30-02
Responsible for the financial systems of the institution. Filed all governmental reports as needed.
Oversight of the following departments.

- Information Technology
- Purchasing
- Patient Fiscal Services (billing)
- Credit
- PatientAccess(registration)

Tasks: Financial management analysis; budget preparation and asset/liability review; accounts payable, accounts receivable, and payroll oversight; inventory and materials management oversight; procurement analysis, contract performance verification. Profit/cost determination, analysis of fund expenditures, recommend contracts.

Member of the Senior Management Team.

Chief Financial Officer
Isaacson Structural Steel, Inc.| Berlin, NH | 1983 – 1995

Education

MBA, Plymouth State University, (Plymouth, NH), 1988
Bachelor of Science in Accounting, Park College (Parkville, Mo), 1982

Military
Served 4 years in the United States Air Force, 1978 – 1982

Alisha M. Nadeau

EDUCATION

UNIVERSITY OF NEW HAMPSHIRE Durham, NH
MS in Nursing, Concentration in Clinical Nurse Leadership August 2015

THE PENNSYLVANIA STATE UNIVERSITY University Park, PA
BS in Biology December 2004

LICENSURE & CERTIFICATIONS

- RN Licensure, New Hampshire Expires November 2022
- Clinical Nurse Leader Certification Expires December 2025
- Basic Life Support for Healthcare Providers, AHA Expires August 2022
- Certified HIPAA Security Professional (CHSP) Expires April 2022

PROFESSIONAL EXPERIENCE

HealthFirst Family Care Center
Senior Director of Clinical Operations July 2021 – Present

- Responsible for the overall operational accountability of the Clinical and Quality Departments
- Oversee THRIVE MAT Program and ensure its ongoing growth both economically as well as the number of patients treated
- Supervise, train, and evaluate staff in the Clinical and Quality Departments, as well as in the THRIVE MAT Program
- In conjunction with the Practice Manager, Behavioral Health Manager, and Medical Director, develop strategies and best practices for quality improvement in support of strategic goals, clinical operations, and clinical programs
- Facilitate the implementation of new programs and procedures resulting from grants and/or changes to federal and state requirements
- Oversee annual state and HRSA requirements, to ensure compliance and timeliness. Compliance responsibilities include, but are not limited to, FTCA application, federal and state site visits, Service Area Competition (SAC), Budget Period Renewals (BPR), Unified Data Subset (UDS) and state quality performance submissions
- Oversee the development and maintenance of written policies and procedures to guide daily operations of the Clinical and Quality Departments and the THRIVE MAT Program to maintain efficient patient flow
- Facilitate in creating and maintaining care management systems to identify and track patients requiring chronic disease care management and high utilizers of healthcare systems
- Research and implement processes involving third parties as fiscally appropriate
- Work with the Medical Director with support of quality improvement initiatives related to clinical indicators, productivity, patient satisfaction, and customer service based on data trends and identified opportunities
- Engage in Provider relations to help influence and impact clinical quality measures and drive improvement with metric performance

- Develop and chair the Life Safety and Risk Management Committee. Implement and manage risk and compliance programs, platforms, and trainings
- Research and implement evidence-based practices in collaboration with clinical staff
- Ensures licensed clinical support staff, RN, LPN, LNA, CMA/RMA, CHW, work within their scope of practice
- Chair the Quality Improvement Committee and provide quarterly reports to the Board of Directors
- Participate in the development and evaluation of department budgets to ensure fiscal responsibility of supervised programs and departments

HealthFirst Family Care Center
Clinical Operations Director July 2020 – July 2021

- Assume overall operational responsibility for Clinical and Quality Departments
- Supervise, train, and evaluate staff in the Clinical and Quality Departments
- Regulate and develop the Compliance, Risk Management, and Safety Programs
- In conjunction with the CMO and CEO, develop strategies and best practices for quality improvement in support of strategic goals, clinical operations, and clinical programs
- Facilitate the implementation of new programs and procedures resulting from grants and/or changes to federal and state requirements
- Oversee the development and maintenance of written policies and procedures to guide daily operations of the Clinical and Quality Departments and maintain efficient patient flow
- Facilitate in creating and maintaining care management systems to identify and track patients requiring chronic disease care management and high utilizers of healthcare systems
- Manage training of staff regarding any changes in policies and procedures resulting from QI initiatives
- Support QI initiatives related to clinical indicators, productivity, patient satisfaction, and customer service based on data trends and identified opportunities
- Oversee insurance carrier incentive programs and aim to increase incentive payments
- Research and implement evidence-based practices in collaboration with clinical staff
- Ensures licensed staff work within their scope of practice
- Provide training and expertise of Centricity EMR documentation
- Submit quarterly and annual performance measures to Board of Directors, state and federal agencies

Amoskeag Health
Director of Wellness and Specialty Services May 2019 – Present

- Responsible for the patient-centered daily operations of 12 Specialty Services departments' care, treatment and services provided, including assisting with implementing new and improved workflows, coordinating efficient organization-wide patient flow, applicable clinical policies and procedures, and communications
- Responsible for NCQA's Patient-Centered Medical Home recognition and re-certification and tasks and responsibilities to achieve and maintain active, successful recognition status

- Collaborate with other departments and work on developing new and improved workflows to improve performance Works closely with the CMO, AMD's, other providers, managers and staff in coordinating training providers/staff as to processes to improve clinic operations
- Initiate and support operational systems and processes to enhance productivity with the support of the CMO and other Senior Managers, Management Team, medical providers, and staff
- Responsible for development of applicable Specialty Services care administrative and/or clinical policies and procedures that continually improve patient care, efficiency, regulatory compliance, and satisfaction
- Develop and maintain written policies and procedures. Assist the Medical Advisory Committee with implementation of new and existing policies, procedures, workflows and approved care standards
- Actively participates in the Quality Improvement Board Committee, CHAN Health Services User Group, Management Team, Safety and Security, Infection Prevention and Control, and Integrated Care Leadership
- Responsible for ensuring comprehensive orientation and training of all clinical employees working in Specialty Services departments supervised
- Oversee and delegate the coordination and completion of specialty department staffing and schedules
- Develop and maintain budgets, projected revenues, staffing plans, operating expenses, capital requests

HealthFirst Family Care Center
Director of Clinical Services May 2017 – May 2019

- Assume overall operational responsibility for Clinical and Quality Departments
- In conjunction with the CMO and CEO, develop strategies and best practices for quality improvement in support of strategic goals, clinical operations, and clinical programs
- Facilitate the implementation of new programs and procedures resulting from grants and/or changes to federal and state requirements
- Oversee the development and maintenance of written policies and procedures to guide daily operations of the Clinical and Quality Departments and maintain efficient patient flow
- Facilitate in creating and maintaining care management systems to identify and track patients requiring chronic disease care management and high utilizers of healthcare systems
- Support QI initiatives related to clinical indicators, productivity, patient satisfaction, and customer service based on data trends and identified opportunities
- Oversee insurance carrier incentive programs and aim to increase incentive payments
- Research and implement evidence-based practices in collaboration with clinical staff
- Submit quarterly and annual performance measures to Board of Directors, state and federal agencies

HealthFirst Family Care Center
Clinical Quality Assurance Manager July 2015 – May 2017

- Responsible for overall quality assurance and quality improvement program

- Facilitate project planning and implementation
- Gather and analyze quality assurance data
- Develop quality measures

NH Public Health Laboratories
Laboratory Scientist III, Molecular Diagnostics Unit April 2008 – January 2014

PROFESSIONAL ORGANIZATIONS

Member, American Nurses Association March 2015 – Present
Member, Sigma Theta Tau Honorary Society of Nursing March 2015 – Present
Member, Alpha Epsilon Delta Honorary Society March 2003 – Present
Member, Sigma Sigma Sigma Sorority April 2001 – Present

PUBLICATIONS

Cavallo, S.J., Daly, E.R., Seiferth, J., Nadeau, A.M., Mahoney, J., Finnigan, J., Wikoff, P. (2015). Human Outbreak of *Salmonella* Typhimurium Associated with Exposure to Locally-made Chicken Jerky Pet Treats, New Hampshire, 2013. *Foodborne Pathogens and Disease, 12*(5).

Daly, E.R., Smith, C.M., Wikoff, P., Seiferth, J., Finnigan, J., Nadeau, A.M., Welch, J.J. (2010). *Salmonella* Enteritidis Infections Associated with a Contaminated Immersion Blender, New Hampshire, 2009. *Foodborne Pathogens and Disease, 7*(9), 1083-1088.

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary Amount Paid from this Contract
Russell Keene	Chief Executive Officer	0
Ted Bolognani	Chief Financial Officer	0
Melissa Fisk	Human Resource Director	0
Dr. Eleanor Janeway	Medical Director	0
Stacey Benoit	Practice Manager	0
Alisha Nadeau	Senior Clinical Operations Director	0
Ashley Douthart	Behavioral Health Manager	0
Audrey Goudie	Marketing Director	0

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-07)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Lamprey Health Care, Inc.		1.4 Contractor Address 207 S. Main St. Newmarket, NH 03857	
1.5 Contractor Phone Number (603) 659-2494	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $1,112,527
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Gregory White Date: 5/19/2022		1.12 Name and Title of Contractor Signatory Gregory White CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt Date: 5/19/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino		On: 5/20/2022	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials DS GW
Date 5/19/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

DS GW

Contractor Initials

Date 5/19/2022

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

Contractor Initials GW

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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Date 5/19/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

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consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Million Hearts Program/Hypertension, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Increase the Percentage of Infants Breastfed, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Adolescents age 12-22 with Annual Home Visit in the Past 12-Months, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

BT-1.0

Exhibit C-1, Budget Sheet

RFP-2022-DPHS-19-PRIMA-07

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Lamprey Health Care*

Budget Request for: *Primary Care Services*

Budget Period *Date of G&C Approval - 6/30/2022*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	37,948.00
2. Fringe Benefits	6,553.00
3. Consultants	-
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	-
5.(a) Supplies - Educational	-
5.(b) Supplies - Lab	-
5.(c) Supplies - Pharmacy	-
5.(d) Supplies - Medical	-
5.(e) Supplies Office	-
6. Travel	-
7. Software	-
8. (a) Other - Marketing/Communications	-
8. (b) Other - Education and Training	-
8. (c) Other - Other (specify below)	
Other (please specify)	-
Other (please specify)	-
Other (please specify)	-
Other (please specify)	-
9. Subrecipient Contracts	-
Total Direct Costs	44,501.00
Total Indirect Costs	-
TOTAL	**44,501.00**

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Contractor Initials GW

Date 5/19/2022

Exhibit C-2, Budget

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Lamprey Health Care*

Budget Request for: *Primary Care Services*

Budget Period *7/1/2022-6/30/2023*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$ 455,065.78
2. Fringe Benefits	$ 78,947.22
3. Consultants	$ -
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$ -
5.(a) Supplies - Educational	$ -
5.(b) Supplies - Lab	$ -
5.(c) Supplies - Pharmacy	$ -
5.(d) Supplies - Medical	$ -
5.(e) Supplies Office	$ -
6. Travel	$ -
7. Software	$ -
8. (a) Other - Marketing/Communications	$ -
8. (b) Other - Education and Training	$ -
8. (c) Other - Other (specify below)	
Other (please specify)	$ -
Other (please specify)	$ -
Other (please specify)	$ -
Other (please specify)	$ -
9. Subrecipient Contracts	$ -
Total Direct Costs	$ 534,013.00
Total Indirect Costs	$ -
TOTAL	**$ 534,013.00**

Contractor Initials DS GW

Date 5/19/2022

Exhibit C-3, Budget

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Lamprey Health Care*
Budget Request for:	*Primary Care Services*
Budget Period	*07/01/2023-06/30/2024*
Indirect Cost Rate (if applicable)	0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$454,920.23
2. Fringe Benefits	$79,092.77
3. Consultants	$0.00
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0.00
5.(a) Supplies - Educational	$0.00
5.(b) Supplies - Lab	$0.00
5.(c) Supplies - Pharmacy	$0.00
5.(d) Supplies - Medical	$0.00
5.(e) Supplies Office	$0.00
6. Travel	$0.00
7. Software	$0.00
8. (a) Other - Marketing/Communications	$0.00
8. (b) Other - Education and Training	$0.00
8. (c) Other - Other (specify below)	
Other (please specify)	$0.00
Other (please specify)	$0.00
Other (please specify)	$0.00
Other (please specify)	$0.00
9. Subrecipient Contracts	$0.00
Total Direct Costs	$534,013.00
Total Indirect Costs	$0.00
TOTAL	**$534,013.00**

Contractor Initials DS GW

Date 5/19/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

5/19/2022
Date

DocuSigned by:
Gregory White
Name: Gregory White
Title: CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/19/2022
Date

DocuSigned by:
Gregory White
706730BE49284D5...
Name: Gregory White
Title: CEO

DS
GW
Vendor Initials
5/19/2022
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

DS
GW

Contractor Initials _____
Date 5/19/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

DocuSigned by:
Gregory White
7D623ABE49284D6...

5/19/2022
Date

Name: Gregory White
Title: CEO

DS
GW

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

5/19/2022
Date

DocuSigned by:
Gregory White
7D623A8E49294D6...
Name: Gregory White
Title: CEO

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Gregory White
7D023A2E48294D0...

5/19/2022
Date

Name: Gregory White
Title: CEO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Lamprey Health Care
The State	Name of the Contractor
Signed by: Iain Watt	DocuSigned by: Gregory White
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Gregory White
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	CEO
Title of Authorized Representative	Title of Authorized Representative
5/19/2022	5/19/2022
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Gregory White

5/19/2022
Date

Name: Gregory White
Title: CEO

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 040254401

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

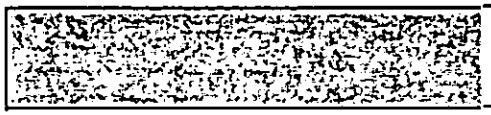
B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1- Screening and Referrals for SDOH

Enabling Services Work Plan Agency Name: Lamprey Health Care Name and Role of Person(s) Completing Work Plan: Susan Hutchinson, QI Manager			
Enabling Services Focus Area: Social Determinants of Health Screening			
Project Goal: Identify and enroll patients eligible for the Sliding Fee Discount Program (SFDP) and insurance enrollment			
Project Objective: To support patients without health insurance in obtaining SFDP assistance and insurance enrollment			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Provide all patients with the new patient packet for completion Assist patients with language, literacy or other barriers	Patient Service Representatives, Community Health Workers and Financial Assistance Coordinator	100% of all patients will have a completed new patient packet	Ongoing
At offsite locations, CHW will interview patients and determine if health insurance is present and will assist patients without health insurance in completing SFDP application	Community Health Worker	100% of patients will have health insurance status documented and applications will be completed for all patients without health insurance	Ongoing
Onsite clinics will run reports in advance of patient appointments and identify patients that could meet with Patient Service Reps and Financial Assistance Coordinator regarding SFDP or insurance enrollment	Patient Service Representative and Financial Assistance Coordinator	Reports on SFDP application and Medicaid assistance are tracked on a monthly basis by site	Ongoing

Attachment #1- Screening and Referrals for SDOH

	Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:
July 2022 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans ortimeline? • Please **give** a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** ___ Yes No	

Attachment #1- Screening and Referrals for SDOH

January 2023 Progress Repqrt- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and	

Attachment #1- Screening and Referrals for SDOH

resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** ___ Yes -- No	
July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22.f,/30/23).	
Did you meet your Target/Objective?	Yes No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** ___ Yes -- No	
July 2023 Project Update **SFY23 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline?	

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Attachment #1- Screening and Referrals for SDOH

• Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** Yes No	
July **2024 Project Update** **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July **2024 Project Update** **SFYZ4 Narrative:** If met–Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year?	
July **2024 Project Update** **SFYZ4 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 - Million Hearts Program/Hypertension

Enabling Services Work Plan Agency Name: Lamprey Healthcare Name and Role of Person(s) Completing Work Plan: Susan Hutchinson, QI Manager			
Enabling Services Focus Area: Million Hearts Program/Hypertension			
Project Goal: Identify patients whose health would benefit from the Million Hearts Program (MHP)			
Project Objective: To increase enrollment in the MHP from 56 to 90 by June 2024 in patients identified with hypertension.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Providers and nurses will obtain patient history and review blood pressure measurements	Nurses and providers	EMR will reflect a diagnoses of hypertension when applicable	Ongoing
Staff will identify patients appropriate to receive blood pressure monitoring equipment	Nurses, providers and QI Coordinator	Patients who received blood pressure equipment will be recorded and tracked	Ongoing
Nurses will provide monthly outreach and address barriers, provide education and support	Nurses	Monthly outreach will be recorded on the tracking sheet for review	Ongoing
Review EMR report quarterly to confirm enrollment. Provide additional training and follow up to staff, if needed, regarding reporting new enrollments to the program	QI Coordinator and EMR Reports	Review EMR report and confirm enrolled patients with tracking sheet	May 2022 and ongoing

Attachment #2 - Million Hearts Program/Hypertension

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

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Date _____

Attachment #2 - Million Hearts Program/Hypertension

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Attachment #2 - Million Hearts Program/Hypertension

Work Plan Revisions submitted: _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 (July 1, 2023 – June 30, 2024)	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 - Increase the Percentage of Infants Breastfed

Quality Improvement Work Plan Agency Name: Lamprey Healthcare Name and Role of Person(s) Completing Work Plan: Susan Hutchinson, QI Manager			
MCH Performance Measure: Percent of infants breastfed			
Project Objective: To increase the percentage of infants breastfed in the past 12-months from 80% to 85% by June 2024			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Assure patients are given education on breastfeeding and that nurses and providers are using the intake packet and the prenatal care plan in the EMR	Prenatal nurses and providers	Follow up with prenatal nurses on education practices	May 2022
Review with prenatal nurses the clinical measure on breastfeeding	QI Manager, QI Coordinator and prenatal nurses	Review completed with all appropriate staff	May 2022
Review the EMR screenshots with staff for proper documentation	QI Manager, QI Coordinator, prenatal nurses and EMR	Training completed with all appropriate staff	June 2022
Review EMR report developed by CHAN and confirm where data is being pulled from in the EMR	QI Manager, QI Coordinator and CHAN IT Department	Report clarified and data confirmed	May 2022
Review data on a quarterly basis and provider additional training if needed	QI Manager, QI Coordinator, EMR and EMR Reports	**Review** *Breastfeeding* report for increases in percentage data	January 2023 and ongoing

Attachment #4 - Increase the Percentage of Infants Breastfed

	QI Work Plan Progress Report Performance Measure: Project Objective:
July **2022 Progress Report-** • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please **give a** brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _ Yes No	
July 2023 Project Update	

Attachment #4 - Increase the Percentage of Infants Breastfed

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	Yes No
July **2023 Project Update** **SFY23 Narrative:** If met–Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** Yes No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** Yes No	
July **2024 Project Update** **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July **2024 Project Update**	

Attachment #4 - Increase the Percentage of Infants Breastfed

SFYZ4 Narrative: If met–Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year	

Attachment #5 - Adolescents age 12-22 with Annual Home Visit in the Past 12-Months

Quality Improvement Work Plan
Agency Name: Lamprey Healthcare
Name and Role of Person(s) Completing Work Plan: Susan Hutchinson, QI Manager

MCH Performance Measure: Adolescents age 12-22 with annual HM visit in the past 12-months

Project Objective: Improve nutrition counseling and exercise education for adolescents 12-16 years old identified with 85% BMI from 60% to 65% by June 2024.

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Develop marketing strategies to increase adolescent well visits to include use of social media, teen clinics, video education and CHW outreach to school nurses and via community events	Marketing Manager, QI Manager Chief of Clinical Services, CHWs	Plan is developed and follow up is completed	June 2022
Review with providers the clinical measure and focus on nutrition counseling and exercise education	QI Manager and QI Coordinator	Training completed with all providers	December 2022
Review EMR screenshots with providers for documentation purposes	QI Manager, QI Coordinator, Weekly Center Updates, EMR	Screenshots included in the center's Weekly Update for review	December 2022
Review data quarterly and provider additional training if needed	QI Manager, QI Coordinator and EMR Reports	Review *Pedi Weight Assessment and Counseling* report for increases in percentage data	January 2023 and ongoing
Add training and education to provider orientation	QI Manager, Provider Orientation Manual	Provider Orientation Manual updated	April 2022

Attachment #5 - Adolescents age 12-22 with Annual Home Visit in the Past 12-Months

[redacted]	QI Work Plan Progress Report [redacted] Performance Measure: Project Objective:
July 2022 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** ___ Yes No	
July 2023 Project Update	

Attachment #5 - Adolescents age 12-22 with Annual Home Visit in the Past 12-Months

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	Yes No
July **2023 Project Update** **SFY23 Narrative:** If met–Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** Yes No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** Yes No	
July **2024 Project Update** **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July **2024 Project Update**	

Attachment #5 - Adolescents age 12-22 with Annual Home Visit in the Past 12-Months

SFYZ4 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year	

Contractor Initials DS GW

Date 5/19/2022

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

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Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

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Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

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Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS GW

5/19/2022

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that LAMPREY HEALTH CARE, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 16, 1971. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **66382**

Certificate Number : **0005770882**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this **29th** day of **April** A.D. **2022.**

David M. Scanlan

Secretary of State

CERTIFICATE OF AUTHORITY

I, Thomas Christopher Drew, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of Lamprey Health Care, Inc.

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on March 25, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Gregory White, CEO, is duly authorized on behalf of Lamprey Health Care, Inc, to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: May 11, 2022

Signature of Elected Officer
Name: Thomas Christopher Drew
Title: Treasurer, Board of Director, Lamprey Health Care

LAMPHEA-01 CSMITH10

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 5/10/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: Lauren Stiles PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: Lauren.Stiles@hubinternational.com
INSURED Lamprey Health Care, Inc. 207 South Main Street Newmarket, NH 03857	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Philadelphia Indemnity Insurance Company — 18058 INSURER B : Atlantic Charter Insurance Company — 44326 INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY							
	CLAIMS-MADE X OCCUR			PHPK2286844	7/1/2021	7/1/2022	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N	N / A		WCA00545409	7/1/2021	7/1/2022	E.L. EACH ACCIDENT	$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

State of New Hampshire
Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

Our Mission

The mission of Lamprey Health Care is to provide high quality primary medical care and health related services, with an emphasis on prevention and lifestyle management, to all individuals regardless of ability to pay.

- We seek to be **a leader in providing access** to medical and health services that improve the health status of the individuals and families in the communities we serve.
- Our mission is to **remove barriers that prevent access to care**; we strive to eliminate such barriers as language, cultural stereotyping, finances and/or lack of transportation.
- Lamprey Health Care's **commitment to the community** extends to providing and/or coordinating access to a full range of comprehensive services.
- Lamprey Health Care is committed to achieving the highest level of patient satisfaction through a personal and caring approach and **exceeding standards of excellence in quality and service**.

Our Vision

- We will be the **outstanding primary care choice** for our patients, our communities and our service area, and the standard by which others are judged.
- We will continue as **pacesetter** in the use of new knowledge for lifestyle improvement, quality of life.
- We will be a **center of excellence** in service, quality and teaching.
- We will be **part of an integrated system** of care to ensure access to medical care for all individuals and families in our communities.
- We will be an **innovator** to foster development of the best primary care practices, adoption of the tools of technology and teaching.
- We will **establish partnerships**, linkages, networks and referrals with other organizations to provide access to a full range of services to meet our communities' needs.

Our Values

- We exist to **serve the needs of our patients**.
- We value a positive **caring approach** in delivering patient services.
- We are committed to **improving the health** and total well-being of our communities.
- We are committed to **being proactive** in identifying and meeting our communities' health care needs.
- We provide a supportive environment for **the professional and personal growth, and healthy lifestyles of our employees**.
- We provide an **atmosphere of learning** and growth for both patients and employees as well as for those seeking training in primary care.
- We succeed by utilizing a **team approach** that values a positive, constructive commitment to Lamprey Health Care's mission.

Affirmed 12/15/2021

BerryDunn

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

CONSOLIDATED FINANCIAL STATEMENTS

and

SUPPLEMENTARY INFORMATION

September 30, 2021 and 2020

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc.

We have audited the accompanying consolidated financial statements of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc., which comprise the consolidated balance sheets as of September 30, 2021 and 2020, and the related consolidated statements of operations, functional expenses, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc. as of September 30, 2021 and 2020, and the results of their operations, changes in their net assets and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, during the year ended September 30, 2021, Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc. adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance. Our opinion is not modified with respect to this matter.

Other Matter

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating balance sheets as of September 30, 2021 and 2020, and the related consolidating statements of operations and changes in net assets for the years then ended, are presented for purposes of additional analysis rather than to present the financial position, results of operations and changes in net assets of the individual entities, and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
January 26, 2022

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Balance Sheets

September 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 3,777,557	$ 3,504,514
Patient accounts receivable	1,389,692	1,396,652
Grants receivable	724,399	658,568
Other receivables	137,513	130,004
Inventory	177,384	129,591
Other current assets	262,941	147,799
Total current assets	6,469,486	5,967,128
Assets limited as to use	4,003,423	2,953,580
Property and equipment, net	7,507,299	7,795,861
Total assets	$17,980,208	$16,716,569

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and accrued expenses	$ 540,324	$ 578,888
Accrued payroll and related expenses	1,306,202	1,322,364
Due to third party payers	241,394	119,639
Deferred revenue	423,922	72,421
Provider Relief Fund refundable advance	-	196,549
COVID-19 Emergency Healthcare System Relief Fund refundable advance	-	250,000
Current maturities of long-term debt	90,068	88,027
Total current liabilities	2,601,910	2,627,888
Long-term debt, less current maturities	2,749,747	2,821,023
Fair value of interest rate swaps	67,441	217,657
Total liabilities	5,419,098	5,666,568
Net assets		
Without donor restrictions	11,947,776	10,579,230
With donor restrictions	613,334	470,771
Total net assets	12,561,110	11,050,001
Total liabilities and net assets	$17,980,208	$16,716,569

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statements of Operations

Years Ended September 30, 2021 and 2020

	2021	2020
Operating revenue		
Net patient service revenue	**$10,386,518**	$ 9,708,842
Rental income	**181,128**	176,353
Grants, contracts and contributions	**8,644,519**	5,663,601
Paycheck Protection Program	**-**	2,152,212
Other operating revenue	**634,309**	410,309
Net assets released from restriction for operations	**364,248**	242,945
Total operating revenue	**20,210,722**	18,354,262
Operating expenses		
Salaries and wages	**11,309,801**	11,106,208
Employee benefits	**2,258,427**	2,096,040
Supplies	**954,094**	747,665
Purchased services	**2,504,470**	1,691,285
Facilities	**667,034**	574,422
Other operating expenses	**860,344**	474,659
Insurance	**140,849**	140,572
Depreciation	**476,470**	462,768
Interest	**102,602**	111,808
Total operating expenses	**19,274,091**	17,405,427
Excess of revenue over expenses	**936,631**	948,835
Change in fair value of interest rate swaps	**150,216**	(231,169)
Grants for capital acquisition	**216,414**	-
Net assets released from restriction for capital acquisition	**65,285**	129,356
Increase in net assets without donor restrictions	**$ 1,368,546**	$ 847,022

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statement of Functional Expenses

Year Ended September 30, 2021

	Healthcare Services	AHEC/PHN	Total Program Services	Administration and Support Services	Total
Salaries and wages	$ 9,107,974	$ 453,641	$ 9,561,615	$ 1,748,186	**$ 11,309,801**
Employee benefits	1,627,746	83,428	1,711,174	547,253	**2,258,427**
Supplies	924,304	6,075	930,379	23,715	**954,094**
Purchased services	1,062,898	418,398	1,481,296	1,023,174	**2,504,470**
Facilities	475,941	26,042	501,983	165,051	**667,034**
Other	379,745	57,277	437,022	423,322	**860,344**
Insurance	-	-	-	140,849	**140,849**
Depreciation	-	-	-	476,470	**476,470**
Interest	-	-	-	102,602	**102,602**
Allocated program support	1,373,345	93,217	1,466,562	(1,466,562)	-
Total	**$ 14,951,953**	**$ 1,138,078**	**$ 16,090,031**	**$ 3,184,060**	**$ 19,274,091**

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statement of Functional Expenses

Year Ended September 30, 2020

	Healthcare Services	AHEC/PHN	Transportation	Total Program Services	Administration and Support Services	Total
Salaries and wages	$ 8,372,143	$ 498,707	$ 69,857	$ 8,940,707	$ 2,165,501	$ 11,106,208
Employee benefits	1,567,514	93,157	12,726	1,673,397	422,643	2,096,040
Supplies	708,447	7,255	-	715,702	31,963	747,665
Purchased services	879,416	114,614	-	994,030	697,255	1,691,285
Facilities	23,488	402	8,652	32,542	541,880	574,422
Other	166,743	61,261	-	228,004	246,655	474,659
Insurance	-	-	7,673	7,673	132,899	140,572
Depreciation	-	-	26,400	26,400	436,368	462,768
Interest	-	-	-	-	111,808	111,808
Allocated program support	754,724	74,216	14,538	843,478	(843,478)	-
Allocated occupancy costs	817,796	35,153	4,641	857,590	(857,590)	-
Total	$ 13,290,271	$ 884,765	$ 144,487	$ 14,319,523	$ 3,085,904	$ 17,405,427

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2021 and 2020

	2021	2020
Net assets without donor restrictions		
Excess of revenue over expenses	$ 936,631	$ 948,835
Change in fair value of interest rate swaps	150,216	(231,169)
Grants for capital acquisition	216,414	-
Net assets released from restriction for capital acquisition	65,285	129,356
Increase in net assets without donor restrictions	1,368,546	847,022
Net assets with donor restrictions		
Contributions	572,096	224,245
Grants for capital acquisition	-	82,721
Net assets released from restriction for operations	(364,248)	(242,945)
Net assets released from restriction for capital acquisition	(65,285)	(129,356)
Increase (decrease) in net assets with donor restrictions	142,563	(65,335)
Change in net assets	1,511,109	781,687
Net assets, beginning of year	11,050,001	10,268,314
Net assets, end of year	$12,561,110	$11,050,001

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statements of Cash Flows

Years Ended September 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	$ 1,511,109	$ 781,687
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	476,470	462,768
Equity in earnings of limited liability company	-	6,877
Change in fair value of interest rate swaps	(150,216)	231,169
Grants for capital acquisition	(216,414)	(82,721)
(Increase) decrease in the following assets:		
Patient accounts receivable	6,960	(39,883)
Grants receivable	(65,831)	(205,857)
Other receivable	(7,509)	106,794
Inventory	(47,793)	(48,107)
Other current assets	(115,142)	(69,394)
(Decrease) increase in the following liabilities:		
Accounts payable and accrued expenses	80,263	(3,984)
Accrued payroll and related expenses	(16,162)	361,340
Due to third-party payers	121,755	-
Deferred revenue	351,501	(12,997)
Provider Relief Fund refundable advance	(196,549)	196,549
COVID-19 Emergency Healthcare System Relief Fund refundable advance	(250,000)	250,000
Net cash provided by operating activities	1,482,442	1,934,241
Cash flows from investing activities		
Equity distribution from limited liability company	-	12,224
Capital acquisitions	(306,735)	(708,997)
Net cash used by investing activities	(306,735)	(696,773)
Cash flows from financing activities		
Grants for capital acquisition	216,414	82,721
Proceeds from issuance of long-term debt	-	2,100,000
Principal payments on long-term debt	(69,235)	(1,328,216)
Net cash (used) provided by financing activities	147,179	854,505
Net increase in cash and cash equivalents and restricted cash	1,322,886	2,091,973
Cash and cash equivalents and restricted cash, beginning of year	6,458,094	4,366,121
Cash and cash equivalents and restricted cash, end of year	$ 7,780,980	$ 6,458,094

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidated Statements of Cash Flows (Concluded)

Years Ended September 30, 2021 and 2020

	2021	2020
Breakdown of cash and cash equivalents and restricted cash, end of year		
Cash and cash equivalents	$ 3,777,557	$ 3,504,514
Assets limited as to use	4,003,423	2,953,580
	$ 7,780,980	$ 6,458,094
Supplemental disclosure of cash flow information		
Cash paid for interest	$ 102,602	$ 111,808
Capital expenditures included in accounts payable	$ -	$ 118,827

The accompanying notes are an integral part of these consolidated financial statements.

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Notes to Consolidated Financial Statements

September 30, 2021 and 2020

Organization

Lamprey Health Care, Inc. (LHC) is a not-for-profit corporation organized in the State of New Hampshire. LHC is a Federally Qualified Health Center (FQHC) whose primary purpose is to provide high quality family health, medical and behavioral health services to residents of southern New Hampshire without regard to the patient's ability to pay for these services.

Subsidiary

Friends of Lamprey Health Care, Inc. (FLHC) is a not-for-profit corporation organized in the State of New Hampshire. FLHC's primary purpose is to support LHC. FLHC is also the owner of the property occupied by LHC's administrative and program offices in Newmarket, New Hampshire. LHC is the sole member of FLHC.

1. Summary of Significant Accounting Policies

Basis of Presentation

The consolidated financial statements of the Organization have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which require the Organization to report information in the consolidated financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of the Organization's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity, of which there were none in 2021 or 2020.

Principles of Consolidation

The consolidated financial statements include the accounts of LHC and its subsidiary, FLHC (collectively, the Organization). All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Income Taxes

Both LHC and FLHC are public charities under Section 501(c)(3) of the Internal Revenue Code. As public charities, the entities are exempt from state and federal income taxes on income earned in accordance with their tax-exempt purposes. Unrelated business income is subject to state and federal income tax. Management has evaluated the Organization's tax positions and concluded that the Organization has no unrelated business income or uncertain tax positions that require adjustment to the consolidated financial statements.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the State of New Hampshire and the Center for Disease Control and Prevention, the Organization took steps to create safe distances between both staff and patients. All providers received the necessary equipment to allow for medical and behavioral health visits using telehealth. Facility modifications included installation of plexi-glass partitions, restructuring of work stations to allow for 6 feet between staff, heating, ventilation, and air conditioning systems were modified to improve air exchange rates and tents and awnings were setup to allow screening, testing and vaccine administration outside of the four walls of the clinics. In addition, the Organization created contained infection control wings at all sites to evaluate and treat patients that screen positive for COVID-19 and deployed a mobile health van to provide testing, vaccination and other service capacity to other areas of the community.

The Organization received a loan in the amount of $2,152,212 in April 2020 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act. The PPP was subject to forgiveness, upon the Organization's request, to the extent that the proceeds were used to pay qualifying expenditures, including payroll costs, rent and utilities, incurred by the Organization during a specific covered period. The Organization determined the conditions for forgiveness were substantially met during the year ended September 30, 2020 and recorded revenue equal to the full amount of the PPP. The Organization was notified in June 2021 the PPP was fully forgiven by the SBA and the lender. The PPP can be audited by the SBA for up to six years from the date of forgiveness.

The CARES Act and the PPPHCE Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services (HHS). The Organization received PRF in the amount of $196,549 during the year ended September 30, 2020, incurred qualifying expenditures of $196,549 during the year ended September 30, 2021 and recorded grant revenue equal to the qualifying expenditures in 2021. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, the amount of income allowed to be recognized may change. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

During May 2020, the Organization received a loan in the amount of $250,000 from the COVID-19 Emergency Healthcare System Relief Fund (Relief Loan), a program implemented by the State, Department of Health and Human Services and available for use through December 30, 2020. The Relief Loan had the potential to be converted to a grant at the sole discretion of the State. The Relief Loan was converted to a grant on October 9, 2020 and recognized as revenue at that time.

Cash and Cash Equivalents

Cash and cash equivalents consist of business checking and savings accounts as well as petty cash funds.

The Organization maintains cash balances at several financial institutions. The balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000. At various times throughout the year, the Organization's cash balances may exceed FDIC insurance. The Organization has not experienced any losses in such accounts and management believes it is not exposed to any significant risk.

Revenue Recognition and Patient Accounts Receivable

During the year ended September 30, 2021, the Organization has adopted Financial Accounting Standards Board Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance, which supersedes accounting standards that previously existed under U.S. GAAP and provides a single revenue model to address revenue recognition to be applied by all companies. Under the new standard, organizations recognize revenue when a customer obtains control of promised goods or services in an amount that reflects the consideration to which the organization expects to be entitled in exchange for those goods and services. Topic 606 also requires organizations to disclose additional information, including the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The Organization elected to adopt this ASU retrospectively with the cumulative effect recognized at the date of initial application; therefore, the consolidated financial statements and related notes have been presented accordingly.

The adoption of Topic 606 had no impact on the Organization's net assets, results of its operations, or cash flows. The adoption of Topic 606 did change how implicit price concessions are presented in the consolidated financial statements. Under the previous standards, the estimate for amounts not expected to be collected based upon historical experience was reflected as a provision for doubtful accounts, and presented separately as an offset to net patient service revenue. Under the new standards, the estimate for amounts not expected to be collected based on historical experience continues to be recognized as a reduction to net revenue, but not reflected separately as provision for doubtful accounts.

The impact of the adoption on the consolidated statement of operations for the year ended September 30, 2020 was as follows:

	As Originally Reported	Adjustments due to Topic 606 Adoption	Revised Balance
Patient service revenue	$ 10,206,803	$ (497,961)	$ 9,708,842
Provision for bad debts	(497,961)	497,961	-
Net patient service revenue	$ 9,708,842	$ -	$ 9,708,842

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payers (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Organization. The Organization measures the performance obligation for medical, behavioral health and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Organization measures the performance obligation for contract pharmacy services based on when the prescription is dispensed to the patient as reported to the Organization by the third-party administrator. The Organization's performance obligations are satisfied at a point in time.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Organization's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience.

Consistent with the Organization's mission and FQHC designation, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Organization expects to collect based on its collection history with those patients.

The Organization has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payer. In assessing collectability, the Organization has elected the portfolio approach. The portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers (patients). The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payer or group of payers will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. Payer concentrations are disclosed in Note 9.

The Organization bills the patients and third-party payers several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Organization is primarily reimbursed for medical, behavioral health and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other services are reimbursed based on fee-for-service rate schedules.

Medicaid

The Organization is primarily reimbursed for medical, behavioral health and ancillary services based on prospectively set rates for an encounter furnished to a Medicaid beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other services are reimbursed based on fee-for-service rate schedules.

Other Payers

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Organization is reimbursed for services based on contractually obligated payment rates for each Current Procedural Terminology code, which may be less than the Organization's public fee schedule.

Patients

The Organization provides care to patients who meet certain criteria under its sliding fee discount policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization's sliding fee discount policy amounted to $1,000,557 and $1,041,631 for the years ended September 30, 2021 and 2020, respectively. The Organization is able to provide these services with a component of funds received through local community support and federal grants.

For uninsured patients who do not qualify under the Organization's sliding fee discount program, the Organization bills the patient based on the Organization's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Organization does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

340B Contract Pharmacy Program Revenue

The Organization, as an FQHC, is eligible to participate in the 340B Drug Pricing Program. This program requires drug manufacturers to provide outpatient drugs to FQHCs and other covered entities at a reduced price. The Organization contracts with local pharmacies under this program. The contract pharmacies dispense drugs to eligible patients of the Organization and bill commercial insurances on behalf of the Organization. Reimbursement received by the contract pharmacies is remitted to the Organization, less dispensing and administrative fees. The dispensing and administrative fees are costs of the program and not deemed to be implicit price concessions which would reduce the transaction price.

Laws and regulations governing the Medicare, Medicaid and 340B programs are complex and subject to interpretation. Management believes that the Organization is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare, Medicaid, and 340B programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances and consisted of the following at September 30:

	2021	2020
Medical and dental patient accounts receivable	$ 1,210,952	$ 1,099,010
Contract 340B pharmacy program receivables	178,740	297,642
Total patient accounts receivable	$ 1,389,692	$ 1,396,652

Accounts receivable at October 1, 2019 were $1,237,130.

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. The accounts receivable from patients and third-party payers, net of allowances, were as follows at September 30:

	2021	2020
Governmental plans		
Medicare	22 %	20 %
Medicaid	35 %	33 %
Commercial payers	21 %	24 %
Patient	22 %	23 %
Total	100 %	100 %

Grants and Other Receivables

Grants and other receivables are stated at the amount management expects to collect from outstanding balances. All such amounts are considered collectible.

The Organization receives a significant amount of grants from HHS. As with all government funding, these grants are subject to reduction or termination in future years. For the years ended September 30, 2021 and 2020, grants from HHS (including both direct awards and awards passed through other organizations) represented approximately 78% and 80%, respectively, of grants, contracts and contributions revenue.

A portion of the Organization's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Organization has met the performance requirements or incurred expenditures in compliance with specific contract or grant provisions, as applicable. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue. The Organization has been awarded cost reimbursable grants in the amount of $3,779,537 and $2,968,196, which are primarily available through May and June 2022 and March 2023, respectively, that have not been recognized at September 30, 2021 because qualifying expenditures have not yet been incurred.

The Organization also received a capital grant, *Health Center Infrastructure Support*, in the amount of $671,534, which is available for use for approved capital projects through September 14, 2024. The Organization intends to use this grant for renovations of the Organization's Nashua, New Hampshire facility. See Note 4 for further discussion regarding the project.

Assets Limited as to Use

Assets limited as to use include cash and cash equivalents designated by the Board of Directors for specific projects or purposes as discussed further in Note 3.

Property and Equipment

Property and equipment are carried at cost. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. The Organization's capitalization policy is applicable for acquisitions greater than $5,000.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations as net assets released from restriction. Contributions whose restrictions are met in the same period as the support was received are recognized as net assets without donor restrictions.

Functional Expenses

The consolidated financial statements report certain categories of expenses that are attributable to more than one program or supporting function of the Organization. Expenses allocated between program services and administrative support include employee benefits which are allocated based on direct wages, facilities which are based upon square footage occupied by the program, human resources and information technology which is based upon employee worked hours attributed to the program.

Excess of Revenue over Expenses

The consolidated statements of operations reflect the excess of revenue over expenses. Changes in net assets without donor restrictions, which are excluded from this measure include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets) and changes in fair value of an interest rate swap that qualifies for hedge accounting.

Subsequent Events

For purposes of the preparation of these consolidated financial statements, management has considered transactions or events occurring through January 26, 2022, the date that the consolidated financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the consolidated financial statements.

2. Availability and Liquidity of Financial Assets

The Organization regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Organization has various sources of liquidity at its disposal, including cash and cash equivalents and a line of credit (Note 5).

The Organization had working capital of $3,867,576 and $3,339,240 at September 30, 2021 and 2020, respectively. The Organization had average days cash and cash equivalents on hand (based on normal expenditures) of 73 and 75 at September 30, 2021 and 2020, respectively.

Financial assets available for general expenditure within one year as of September 30 were as follows:

	2021	2020
Cash and cash equivalents	$ 3,777,557	$ 3,504,514
Patient accounts receivable, net	1,389,692	1,396,652
Grants receivable	724,399	658,568
Other receivables	137,513	130,004
Financial assets available	$ 6,029,161	$ 5,689,738

The Organization has certain board-designated assets limited as to use which are available for general expenditure within one year in the normal course of operations upon obtaining approval from the Board of Directors and other assets limited as to use for donor-restricted purposes, which are more fully described in Note 3. Accordingly, these assets have not been included in the quantitative information above.

The Organization's goal is generally to have, at the minimum, the U.S. Health Resources and Services Administration recommended days cash and cash equivalents on hand for operations of 30 days.

3. Assets Limited as To Use

Assets limited as to use are made up of cash and cash equivalents which are to be used for the following purposes at September 30:

	2021	2020
Board-designated for		
Transportation	$ 27,059	$ 16,982
Working capital	1,641,947	1,391,947
Capital improvements	1,677,051	1,139,165
Other	79,755	-
Total board-designated	3,425,812	2,548,094
Donor restricted	577,611	405,486
Total	$ 4,003,423	$ 2,953,580

4. Property and Equipment

Property and equipment consists of the following at September 30:

	2021	2020
Land and improvements	$ 1,154,753	$ 1,154,753
Building and improvements	11,831,191	11,661,674
Furniture, fixtures and equipment	1,835,579	1,887,073
Total cost	14,821,523	14,703,500
Less accumulated depreciation	7,397,168	7,115,614
	7,424,355	7,587,886
Construction in progress and assets not in service	82,944	207,975
Property and equipment, net	$ 7,507,299	$ 7,795,861

The construction in progress at September 30, 2021 primarily relates to the renovations of the Organization's Nashua, New Hampshire facility to expand clinical space and reconfigure existing space for improved workflows for increased patient access and improved patient experience. The total project cost is estimated at $2,548,439 and anticipated to be funded by a capital grant, board designated and donor restricted cash and debt financing. The renovation is projected to be completed before the expiration of the capital grant in September 2024.

Property and equipment acquired with Federal grant funds are subject to specific federal standards for sales and other dispositions. In many cases, the Federal government retains a residual ownership interest in the assets, requiring prior approval and restrictions on disposition.

5. Line of Credit

The Organization has an available $1,000,000 revolving line of credit from a local bank through May 2022, with an interest rate at Prime, but not less than 3.25% (3.25% at September 30, 2021). The line of credit is collateralized by all business assets. There was no outstanding balance as of September 30, 2021 and 2020.

6. Long-Term Debt

Long-term debt consists of the following at September 30:

	2021	2020
Promissory note payable to local bank; see terms outlined below. (1)	$ 811,195	$ 829,242
Promissory note payable to local bank; see terms outlined below. (2)	2,028,620	2,079,808
Total long-term debt	2,839,815	2,909,050
Less current maturities	90,068	88,027
Long-term debt, less current maturities	$ 2,749,747	$ 2,821,023

(1) The Organization has a promissory note with a local bank which is a ten-year balloon note to be paid at the amortization rate of 30 years, with variable monthly payments of principal and interest at 85% of the one-month LIBOR rate plus 2.125% through February 2022 when the balloon payment is due. The note is collateralized by the real estate. The Organization has an interest rate swap agreement for the ten-year period through 2022 that limits the potential interest rate fluctuation and substantively fixes the rate at 4.13%. On December 17, 2021, the Organization received a commitment from a local bank to refinance the debt with a ten-year balloon note to be paid at the amortization rate of 30 years, with variable monthly payments of principal and interest and will obtain another interest rate swap agreement resulting in a fixed rate of 3.46%. Maturities have been presented based on the terms of the refinancing.

(2) The Organization has a promissory note with a local bank which is a ten-year balloon note to be paid at the amortization rate of 30 years, with variable monthly principal payments plus interest at the one-month LIBOR rate plus 1.5% through October 2029 when the balloon payment is due. The note is collateralized by the real estate. The Organization has an interest rate swap agreement for the ten-year period through 2029 that limits the potential interest rate fluctuation and substantially fixes the rate at 3.173%.

The Organization is required to meet certain administrative and financial covenants under the loan agreements included above. In the event of default, the bank has the option to terminate the agreement and immediately request payment of the outstanding debt without notice of any kind to the Organization. The Organization was in compliance with all loan covenants at September 30, 2021.

Maturities of long-term debt for the next five years and thereafter are as follows at September 30:

2022	$ 90,068
2023	92,538
2024	94,909
2025	97,686
2026	100,374
Thereafter	2,364,240
Total	$ 2,839,815

7. Derivative Financial Instruments

The Organization participates in certain fixed-payer swap contracts related to underlying, variable rate debt obligations. The purpose of these contracts is to protect the Organization against rising interest rates related to the variable rate debt. These contracts qualify for hedge accounting as a cash flow hedge and are reported at fair value as an asset or a liability. As a perfectly effective cash flow hedge, the change in fair value of the contracts is reported in the change in net assets without donor restrictions. The Organization expects to hold the swap contracts until their respective maturities.

The interest swap contract terms are summarized as follows at September 30:

Entity	Fixed Rate Paid	Variable Rate Received	Notional Amount	2021 Fair Value Asset (Liability)	2020 Fair Value Asset (Liability)	Termination Date	Counterparty
LHC	4.1300 %	2.1993 %	$ 805,486	$ (2,632)	$ (18,241)	01-19-2022	TD Bank
FLHC	3.1730 %	1.5825 %	2,017,954	(64,809)	(199,416)	10-02-2029	TD Bank
Cumulative unrealized loss				$ (67,441)	$ (217,657)		

U.S. GAAP establish a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

Level 1 — Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2 — Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3 — Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The Organization uses inputs other than quoted prices that are observable to value the interest rate swaps. The Organization considers these inputs to be Level 2 inputs in the context of the fair value hierarchy. These values represent the estimated amounts the Organization would receive or pay to terminate agreements, taking into consideration current interest rates and the current creditworthiness of the counterparty (present value of expected cash flows).

8. Net Assets

Net assets without donor restrictions are designated for the following purposes at September 30:

	2021	2020
Undesignated	$ 8,521,964	$ 8,031,136
Board-designated (Note 3)	3,425,812	2,548,094
Total	$11,947,776	$10,579,230

Net assets with donor restrictions were restricted for the following specific purposes at September 30:

	2021	2020
Temporary in nature:		
Capital improvements	$ 214,647	$ 214,647
Community programs	382,817	170,745
Substance abuse prevention	15,870	20,094
Grants for capital acquisitions not in service	-	65,285
Total	$ 613,334	$ 470,771

9. Patient Service Revenue

Patient service revenue was as follows for the years ended September 30:

	2021	2020
Gross charges	$14,780,770	$13,852,130
340B contract pharmacy revenue	1,853,873	1,617,196
Total gross revenue	16,634,643	15,469,326
Contractual adjustments and implicit price concessions	(5,684,212)	(5,514,248)
Sliding fee discounts	(777,588)	(811,423)
Other patient related revenue	213,675	565,187
Total patient service revenue	$10,386,518	$ 9,708,842

The mix of net patient service revenue from patients and third-party payers was as follows for the years ended September 30:

	2021	2020
Medicare	14 %	16 %
Medicaid	42 %	46 %
Other payers	41 %	36 %
Self-pay and sliding fee scale patients	3 %	2 %
	100 %	100 %

10. Retirement Plan

The Organization has a defined contribution plan under Internal Revenue Code Section 403(b). The Organization contributed $281,223 and $292,808 for the years ended September 30, 2021 and 2020, respectively.

11. Medical Malpractice

The Organization is protected from medical malpractice risk as an FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of September 30, 2021, there were no known malpractice claims outstanding which, in the opinion of management, will be settled for amounts in excess of either FTCA or medical malpractice insurance coverage, nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

12. Litigation

From time-to-time certain complaints are filed against the Organization in the ordinary course of business. Management vigorously defends the Organization's actions in those cases and utilizes insurance to cover material losses. In the opinion of management, there are no matters that will materially affect the Organization's consolidated financial statements.

SUPPLEMENTARY INFORMATION

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Balance Sheet

September 30, 2021

ASSETS

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	2021 Consolidated
Current assets			
Cash and cash equivalents	$ 2,297,060	$ 1,480,497	$ 3,777,557
Patient accounts receivable	1,389,692	-	1,389,692
Grants receivable	724,399	-	724,399
Other receivables	137,513	-	137,513
Inventory	177,384	-	177,384
Other current assets	262,941	-	262,941
Total current assets	4,988,989	1,480,497	6,469,486
Assets limited as to use	4,003,423	-	4,003,423
Property and equipment, net	5,830,543	1,676,756	7,507,299
Total assets	$ 14,822,955	$ 3,157,253	$ 17,980,208

LIABILITIES AND NET ASSETS

Current liabilities			
Accounts payable and accrued expenses	$ 537,394	$ 2,930	$ 540,324
Accrued payroll and related expenses	1,306,202	-	1,306,202
Due to third party payers	241,394	-	241,394
Deferred revenue	423,922	-	423,922
Due to affiliate			
Due to (from) affiliate	21,985	(21,985)	-
Current maturities of long-term debt	45,072	44,996	90,068
Total current liabilities	2,575,969	25,941	2,601,910
Long-term debt, less current maturities	766,123	1,983,624	2,749,747
Fair value of interest rate swap	2,632	64,809	67,441
Due to (from) affiliate	1,073,876	(1,073,876)	-
Total liabilities	4,418,600	1,000,498	5,419,098
Net assets			
Without donor restrictions	9,791,021	2,156,755	11,947,776
With donor restrictions	613,334	-	613,334
Total net assets	10,404,355	2,156,755	12,561,110
Total liabilities and net assets	$ 14,822,955	$ 3,157,253	$ 17,980,208

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Balance Sheet

September 30, 2020

ASSETS

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	2020 Consolidated
Current assets			
Cash and cash equivalents	$ 2,205,696	$ 1,298,818	$ 3,504,514
Patient accounts receivable	1,396,652	-	1,396,652
Grants receivable	658,568	-	658,568
Other receivables	130,004	-	130,004
Inventory	129,591	-	129,591
Other current assets	147,799	-	147,799
Total current assets	4,668,310	1,298,818	5,967,128
Assets limited as to use	2,953,580	-	2,953,580
Property and equipment, net	6,009,215	1,786,646	7,795,861
Total assets	$ 13,631,105	$ 3,085,464	$ 16,716,569

LIABILITIES AND NET ASSETS

Current liabilities			
Accounts payable and accrued expenses	$ 578,888	$ -	$ 578,888
Accrued payroll and related expenses	1,322,364	-	1,322,364
Due to third party payers	119,639	-	119,639
Deferred revenue	72,421	-	72,421
Provider Relief Fund refundable advance	196,549	-	196,549
COVID-19 Emergency Healthcare System Relief Fund refundable advance	250,000	-	250,000
Due to (from) affiliate	22,604	(22,604)	-
Current maturities of long-term debt	44,453	43,574	88,027
Total current liabilities	2,606,918	20,970	2,627,888
Long-term debt, less current maturities	784,789	2,036,234	2,821,023
Fair value of interest rate swap	18,241	199,416	217,657
Due to (from) affiliate	1,104,410	(1,104,410)	-
Total liabilities	4,514,358	1,152,210	5,666,568
Net assets			
Without donor restrictions	8,645,976	1,933,254	10,579,230
With donor restrictions	470,771	-	470,771
Total net assets	9,116,747	1,933,254	11,050,001
Total liabilities and net assets	$ 13,631,105	$ 3,085,464	$ 16,716,569

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Statement of Operations

Year Ended September 30, 2021

	Lamprey Health Care Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	2021 Consolidated
Operating revenue				
Patient service revenue	$10,386,518	$ -	$ -	$10,386,518
Rental income	181,128	227,916	(227,916)	181,128
Grants, contracts and contributions	8,644,519	-	-	8,644,519
Other operating revenue	634,169	140	-	634,309
Net assets released from restriction for operations	364,248	-	-	364,248
Total operating revenue	20,210,582	228,056	(227,916)	20,210,722
Operating expenses				
Salaries and wages	11,309,801	-	-	11,309,801
Employee benefits	2,258,427	-	-	2,258,427
Supplies	954,094	-	-	954,094
Purchased services	2,504,395	75	-	2,504,470
Facilities	885,776	9,174	(227,916)	667,034
Other operating expenses	856,309	4,035	-	860,344
Insurance	140,849	-	-	140,849
Depreciation	366,581	109,889	-	476,470
Interest expense	86,613	15,989	-	102,602
Total operating expenses	19,362,845	139,162	(227,916)	19,274,091
Excess of revenue over expenses	847,737	88,894	-	936,631
Change in fair value of interest rate swap	15,609	134,607	-	150,216
Grants for capital acquisition	216,414	-	-	216,414
Net assets released from restriction for capital acquisition	65,285	-	-	65,285
Increase in net assets without donor restrictions	$ 1,145,045	$ 223,501	$ -	$ 1,368,546

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Statement of Operations

Year Ended September 30, 2020

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	2020 Consolidated
Operating revenue				
Patient service revenue	$ 9,708,842	$ -	$ -	$ 9,708,842
Rental income	176,353	227,916	(227,916)	176,353
Grants, contracts and contributions	5,663,601	-	-	5,663,601
Paycheck Protection Program	2,152,212	-	-	2,152,212
Other operating revenue	410,188	121	-	410,309
Net assets released from restriction for operations	242,945	-	-	242,945
Total operating revenue	18,354,141	228,037	(227,916)	18,354,262
Operating expenses				
Salaries and wages	11,106,208	-	-	11,106,208
Employee benefits	2,096,040	-	-	2,096,040
Supplies	747,665	-	-	747,665
Purchased services	1,691,103	182	-	1,691,285
Facilities	798,038	4,300	(227,916)	574,422
Other operating expenses	474,659	-	-	474,659
Insurance	140,572	-	-	140,572
Depreciation	352,880	109,888	-	462,768
Interest	79,288	32,520	-	111,808
Total operating expenses	17,486,453	146,890	(227,916)	17,405,427
Excess of revenue over expenses	867,688	81,147	-	948,835
Change in fair value of interest rate swap	(31,753)	(199,416)	-	(231,169)
Net assets released from restriction for capital acquisition	129,356	-	-	129,356
Increase (decrease) in net assets without donor restrictions	$ 965,291	$ (118,269)	$ -	$ 847,022

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Statement of Changes in Net Assets

Year Ended September 30, 2021

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	2021 Consolidated
Net assets without donor restrictions			
Excess of revenue over expenses	$ 847,737	$ 88,894	$ 936,631
Change in fair value of interest rate swap	15,609	134,607	150,216
Grants for capital acquisition	216,414	-	216,414
Net assets released from restriction for capital acquisition	65,285	-	65,285
Increase in net assets without donor restrictions	1,145,045	223,501	1,368,546
Net assets with donor restrictions			
Contributions	572,096	-	572,096
Net assets released from restriction for operations	(364,248)	-	(364,248)
Net assets released from restrictions for capital acquisition	(65,285)	-	(65,285)
Increase in net assets with donor restrictions	142,563	-	142,563
Change in net assets	1,287,608	223,501	1,511,109
Net assets, beginning of year	9,116,747	1,933,254	11,050,001
Net assets, end of year	$10,404,355	$ 2,156,755	$12,561,110

LAMPREY HEALTH CARE, INC. AND FRIENDS OF LAMPREY HEALTH CARE, INC.

Consolidating Statement of Changes in Net Assets

Year Ended September 30, 2020

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	2020 Consolidated
Net assets without donor restrictions			
Excess of revenue over expenses	$ 867,688	$ 81,147	$ 948,835
Change in fair value of interest rate swap	(31,753)	(199,416)	(231,169)
Net assets released from restriction for capital acquisition	129,356	-	129,356
Increase (decrease) in net assets without donor restrictions	965,291	(118,269)	847,022
Net assets with donor restrictions			
Contributions	224,245	-	224,245
Grants for capital acquisition	82,721	-	82,721
Net assets released from restrictions for operations	(242,945)	-	(242,945)
Net assets released from restriction for capital acquisition	(129,356)	-	(129,356)
Decrease in net assets with donor restrictions	(65,335)	-	(65,335)
Change in net assets	899,956	(118,269)	781,687
Net assets, beginning of year	8,216,791	2,051,523	10,268,314
Net assets, end of year	$ 9,116,747	$ 1,933,254	$11,050,001

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

2022 Board of Directors

Frank Goodspeed (President/Chair)

Term Ends 2023
Affiliation: Tropic Star Development
Years of Service: 8

Arvind Ranade, (Vice President)

Term Ends 2024
Affiliation: SymbioSys Solutions, Inc.
Years of Service: 6

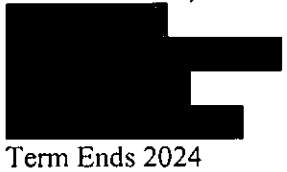
Thomas "Chris" Drew (Treasurer)

Term Ends 2022
Affiliation: Seacoast Mental Health Center
Years of Service: 23

Laura Valencia (Secretary)

Term Ends 2024
Affiliation: Johnson Matthey
Years of Service: 3

Audrey Ashton-Savage (Immediate Past Chair/President)



Term Ends 2024
Affiliation: University of New Hampshire
Years of Service: 31

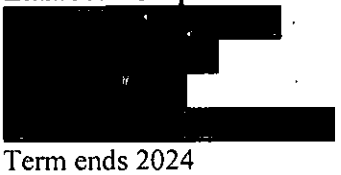
Michelle Boom

Term Ends 2022
Affiliation: Homemaker
Years of Service: 2

James Brewer

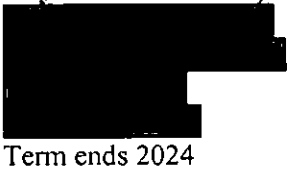
Term Ends 2022
Affiliation: Kennebunk Savings Bank
Years of Service: 2

Elizabeth Crepeau



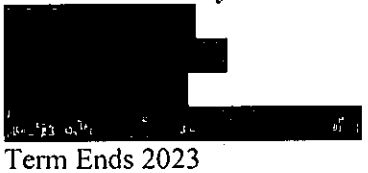
Term ends 2024
Affiliation: Retired
Years of Service: 15

Raymond Goodman, III



Term ends 2024
Affiliation: Children's Trust
Years of Service: 9

Todd J Hathaway



Term Ends 2023
Affiliation: Wadleigh, Starr & Peters, PLLC
New Board Member

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

2022 Board of Directors

Carol LaCross

[redacted]

Term Ends 2024
Affiliation: Retired
Years of Service: 33

Andrea Laskey

[redacted]

Term Ends 2022
Affiliation: Retired
Years of Service: 2

Mark Marandola

[redacted]

Term Ends 2023
Affiliation: Fidelity
Years of Service: 1

Michael Reinke

[redacted]

Term Ends 2023
Affiliation: Nashua Soup Kitchen & Shelter
Years of Service: 1

Samantha Stamas

[redacted]

Term Ends 2023
Affiliation: Rivier University
New Board Member

Wilberto Torres

[redacted]

Term Ends 2022
Affiliation: Torres Management and Research Corporation
Years of Service: 4

Robert S. Woodward

[redacted]

Term Ends 2022
Affiliation: Retired
Years of Service: 5

Gregory A. White, CPA

[redacted]

Summary

Senior Level Executive with extensive hands-on experience in management, business leadership, and working with boards, banks and other external stake holders. A CPA with an established record of success in Community Health Center management. Strong in budgets, cash forecasts, grants, and team leadership.

Professional Experience

Lamprey Health Care – Newmarket, NH **2013 to present**

Chief Executive Officer

- Responsible for the leadership, operation and overall strategic direction of New Hampshire's largest Federally Qualified Health Center.
- Ensuring continuity and high quality primary medical care in three sites, both urban rural, serving over 16,000 patients in 40 communities.
- Leading a high performing senior management team in the direction of over 150 staff and providers.
- Engaging with leaders and stakeholders at the local, state and national levels to ensure that Lamprey is at the forefront of innovative, high quality health care delivery.

Lowell Community Health Center – Lowell, MA **2009 to 2013**

Chief Financial Officer

- Responsible for the integrity of financial information and systems for this Federally Qualified Health Center, employing 315 staff and providing over 120,000 visits annually. Upgraded financial and administrative infrastructure to meet requirements during a time of rapid expansion.
- Lead the financing and budget development for a $42 million capital facility project to include: traditional debt, multiple tax credit sources, federal grants, loan guarantees, and private funds.
- Directed key projects for: 340(b) pharmacy implementation; 403(b) tax deferred savings plan; multiple federal stimulus grants; and revised operating budget development.
- Representative to the Lowell General PHO for managed care contract negotiation
- Recruited and managed a team of five directors to oversee and manage four support and one programmatic department

Manchester Community Health Center – Manchester, NH **1999 to 2009**

Chief Financial Officer

- Recruited by the CEO to bring structure and process to the functional areas of the Center's financial operations. Provided direction and oversight to key business areas; General Administration, Patient Registration, Human Resources, FTCA/Legal and Medical Records.

- Responsible for the development of key programs, Corporate Compliance, HIPAA, selection of a new practice management system. Supported Joint Commission accreditation and the implementation of an electronic medical record system.
- Led the development of financing for the Center's new facility.

Greater Lawrence Family Health Center – Lawrence, MA **1993 to 1998**

Controller **1997 to 1998**

Accounting Manager **1995 to 1997**

Senior Accountant/Analyst **1993 to 1995**

- Progressively responsible for all day to day financial operations of a Federally Qualified Health Center, including: Accounts Payable, Payroll, General Ledger, Cash Management, Cost Reporting, Patient Accounts, and Financial Reporting. Presented budgets, analysis, projections and periodic reporting to the Board of Directors.
- Key leader for projects involving: selection of new financial accounting software; selection of new practice management system; provider productivity measurement and analysis and group purchasing. Oversaw budget of $5 million construction project.
- Developed reimbursement model for an innovative Family Practice Residency program.

Alexander, Aronson, Finning & Co., CPA's – Westborough, MA **1990 to 1993**

Staff Accountant/Auditor

Education & Professional Affiliations

Babson College, Wellesley, MA

BS, Accounting - 1990

Commonwealth of Massachusetts

Certified Public Accountant- 1996

Healthcare Financial Management Association

Certified Healthcare Financial Professional - 2008

National Association of CHC's

Excel Leadership Program - 2003

National Registry of Emergency Medical Technicians

EMT - N.H. license number 18991-1

Boards, Advisory & Volunteer Experience

Massachusetts League of Community Health Centers – Special Finance Committee

Gregory A. White, CPA

[redacted]

NH Health Access Network – Administrative & Training Committee

Community Health Access Network – Board of Directors, Finance Committee

Bi-State Primary Care Association – Capital Finance & Sustainability, Prospective Payment

The Way Home – Manchester, NH - Board of Trustees – Treasurer

Manchester Sustainable Access Project – Data Sub-group

Milford Ambulance Service – Volunteer EMT, Staff Officer, Treasurer, Building Advisory Committee

Milford Educational Foundation – 1999 to 2010 - Treasurer

Heritage United Way – Manchester – Community Investment Committee

Milford Community Athletic Association - Coach

Lasell College – Co-Resident Director

Evalie M. Crosby, CPA, FHFMA

[redacted]

Summary of Qualifications

Thirty-three years professional accounting and healthcare finance experience including audit, residential mental health, critical access hospital and FQHC managerial experience. Responsibilities have included extensive involvement in third-party contract negotiations, budgeting, strategic planning, financial analysis of strategic initiatives, independent financial audit and IRS Form 990 coordination and full responsibility for preparation and filing of Medicare and Medicaid Cost Reports. Served in all executive positions in NHVT HFMA which has provided significant exposure to PPS hospital and NH and VT healthcare organization executive and managerial level leaders.

Experience

Lamprey Health Care, Inc, Newmarket, NH
Chief Financial Officer (2016 – Present)

Senior Executive of Finance for a three site Federally Qualified Health Center serving over 15,000 patients in southern New Hampshire.

- Responsible for overall fiscal management of multi-site Federally Qualified Health Center with a $15+ million dollar annual budget. Management includes budgeting, strategic planning, month end close and reporting to the Board of Directors.
- Redesigned and rebuilt company chart of accounts and reporting to more efficiently and accurately reflect financial operating results at the departmental, programmatic and grant levels of the health center.
- Preparation and execution of financial and retirement plan audits.
- Preparation and execution of tri-ennial HRSA site visit financial review.
- Conducted search and selection of Financial Advisor firm for 403B Retirement Plan.

Alice Peck Day Health System, Lebanon, NH
Vice President of Finance/Chief Financial Officer (2009-Present)

Senior Executive of Finance for Health System comprised of Alice Peck Day Memorial Hospital made up of a 25 bed Critical Access Hospital and 11 wholly owned Physician Practices and Alice Peck Lifecare, a senior living facility with 66 independent living units, 66 assisted living units and 7 24/7 supervised nursing units. Responsible for 6 direct reports and 69 employees from Revenue Cycle, Patient Access, Patient Accounts, Coding, Health Information, Materials Management, Fiscal Services and Lifecare Business Services. Prior to Senior Level restructuring CFO was responsible for IT/IS and Risk/Compliance.

- Responsible for overall financial and fiscal management aspects of Health Systems, Hospital and Lifecare operations including accounting, budgetary, tax and other financial planning activities within the health system organizations;
- Create, coordinate, and evaluate the financial programs and supporting information systems to include budgeting, tax planning, real estate, and conservation of assets.
- Approve and coordinate changes and improvements in automated financial and management information systems for the organizations of the APD Health Systems.
- Ensure compliance with local, state, and federal financial reporting requirements.
- Coordinate the preparation of financial statements, financial reports, Medicare Cost Reports, 990 Tax Returns, special analyses, and information reports.
- Develop and implement finance, accounting, billing, and auditing procedures.
- Establish and maintain appropriate internal control safeguards.
- Contribute financial expertise in the planning of new services that generate additional sources of revenue.
- Manage costs by continually seeking data that will identify opportunities that eliminate non-value costs in conjunction with the Senior Leadership Teams of the Hospital and Lifecare.
- Analyzes areas in planning, promoting and conducting organization-wide performance improvement activities.
- Interact with other managers to provide consultative support to planning initiatives through financial and management information analyses, reports, and recommendations.
- Develop and direct the implementation of strategic business and/or operational plans, projects, programs, and systems, in conjunction with other members of the Senior Leadership Teams.
- Establish and implement short- and long-range departmental goals, objectives, policies, and operating procedures.
- Negotiate and execute third party payor contracts.
- Represent the health system at meetings including medical staff, board of trustee meetings, New Hampshire Hospital Association, New England Alliance for Health, and other relevant community meetings as needed.
- Represent the company externally to media, government agencies, funding agencies, and the general public.
- Recruit, train, supervise, and evaluate department staff.

Mt. Ascutney Hospital and Health Center, Windsor, VT
Budgeting and Reimbursement Manager and Controller (2001-2009)
Progressive managerial experience ranging from budget and reimbursement manager to Controller and succession plan that would transition to Chief Financial Officer. Directly supervise 4 employees in Finance and serve as backup supervisor for 30 employees in four departments reporting to the Chief Financial Officer including Materials Management, IT, Patient Access and Patient Accounts.

- Plan, organize and coordinate annual budget process for Critical Access Hospital. Process involves collection and distribution of departmental historical volume, revenue and expense data; supporting department heads in the development of their operating

budgets; performing financial analysis on proposed changes in services; and presenting proposed budget for approval by the Board of Trustees Finance and Audit Committee. Prepared and coordinated the presentation of the Hospital's proposed budget before the State of Vermont Banking, Insurance, Securities and Healthcare Administration (BISHCA) and Public Oversight Commission (POC).

- Serve as Hospital's direct finance contact for BISHCA staff, Medicaid Personnel, CMS personnel, and other contract agencies and third party payors.
- Prepare annual Medicare and Medicaid Cost Report filings and all supporting documentation.
- Coordinate annual financial audit process and serve as hospital's primary contact for all external audit engagements including but not limited to Independent Financial Auditors, Medicaid Auditors and Medicare Auditors.
- Develop and present finance workshops for clinical department heads. Serve as primary contact in the finance area for clinical department heads. Participate in Senior Management Team meetings. Participate in monthly Board of Trustee Finance and Audit Committee meetings.
- Implemented decision support software system which has successfully led to automation of monthly departmental variance reporting as well as much of the annual budget process.
- Responsible for updating and maintenance of Revenue and Estimated Third Party Settlement Models which are integral to the budgeting and monthly reporting processes.

Namaqua Center, Loveland, CO
Chief Financial Officer (1998-2001)
Responsible for the evaluation of automated accounting systems as well as the ultimate selection and implementation of the system. Directly supervised 3 employees and responsible for all aspects of the financial performance of the agency. Served as liaison with regulatory agencies, both for written reporting and on-site surveys.

- Developed full accounting policies and procedures manual for the agency.
- Direct contact for Independent Auditors and State Regulatory Agencies involved in financial oversight of the Agency's operations and effectiveness.
- Assured timely and complete Medicaid Cost Reports and School Department Reporting packages.
- Coordinated extensive Quality Improvement Project around third party reporting and billing.

Evalie M. Crosby, CPA
Principal (1985-1997)
Built a full public accounting practice servicing primarily small business, not for profit and individual clients. Successfully represented clients before the Internal Revenue Service, State Departments of Revenue, State Departments of Employment and Training, and Workers Compensation Insurers. Negotiated financing for clients with financial institutions and a variety of Federal and State Grant agencies.

- Provided monthly accounting and bookkeeping services.
- Provided quarterly and annual payroll and income tax filing assistance.
- Consulted with clients on the selection, installation and implementation of automated accounting systems.

Deloitte Haskins + Sells, Boston, MA
Healthcare Audit Team, (1982-1985)

- Served in a variety of capacities from audit staff to audit senior on the Healthcare Audit Team for a major public accounting firm in Boston, MA.
- Planned, organized and supervised audits on a variety of healthcare engagements.
- Served as a member of the initial DH+S team for Brigham and Women's Hospital and New England Deaconess Hospital engagements.

Education

Master of Science in Accounting **1982**
Northeastern University Graduate School of Professional Accounting, Boston, MA

Bachelor of Arts - Economics **1980**
Tufts University, Medford, MA

Current Certifications/Affiliations

Healthcare Finance Management Association (HFMA)

Fellow of Healthcare Financial Management Association (FHFMA) 2007-Present

Certified Healthcare Finance Professional with Specialty in Physician Practices (1984-Present)

NHVT Executive Board (All positions, 2008-2012)

Certification Committee Co-Chair (2005-2008)
Received Yerger Award for Innovation (2007)

Newsletter Committee (2005-2008)
Authored several articles for the Chapter-s bi-monthly newsletter

Education Committee (2004-2008)
Presenter for four separate HFMA and MGMA Education Sessions
Co-Coordinator for a minimum of two sessions per year

Certified Public Accountant (1984-Present)

Commonwealth of Massachusetts	1984-1997
State of Colorado	1997-2001
State of New Hampshire	2001-Present

Speaking Engagements

Healthcare Financial Management Association

HFMA Core Coaching Preparation Course	August 2008 September 2009
The Role of Patient Accounts in the Revenue Cycle	October 2009
Medicare Cost Report Boot Camp	January 2010
Introduction to Healthcare Finance for Trustees	January 2010
Basic Healthcare Finance for Non Financial Professionals	October 2010

American Institute of Certified Public Accountants

Healthcare Industry Annual Conference	November 2012

Alice Peck Day Health System

Finance Topics for the Non-Financial Manager	Monthly Lunch and Learns

River Valley Community College

Adjunct Faculty for "Healthcare Accounting and Finance"	Sept 2015 – Dec 2015

VASUKI NAGARAJ M.D., M.P.H. [redacted]

SPECIALITY **Family Medicine**

EDUCATION

Master of Public Health, ***Aug 2001 – Dec 2003***
Environmental and Occupational Health
Texas A&M University-HSC, College Station, Texas
Bachelor of Medicine and Surgery (M.B.B.S) ***Aug 1995 – Apr 2000***
J.J.M. Medical College, Davangere, India *Kuvempu University*

HONORS

- Financed 75% of entire Medical Education through Government based merit, and 100% of my MPH degree through graduate assistantships.
- Ranked in the top 5% of the graduating class of 2001 in Medical School.
- Inducted into the Alpha Tau chapter of the Delta Omega Public Health Honor Society in April, 2004.
  The Delta Omega Society recognizes scholarship merit (top 10% of students) and reflects dedication to quality in the field of Public Health.

RESEARCH

Texas A&M University, Research Assistant ***Aug 2001- Aug 2003***
Rio Bravo Child Pesticide Ingestion Project, P.I. – K.C. Donnelly, PhD.

- The primary focus of this study is to develop a methodology to estimate childhood exposure to pesticide through the sampling of house dust and children's hand rinse and urine samples. My duties included Coordinating research communication; Leading a team involved in generating reports, writing protocols, and handling sampling tools; Analyzing and maintaining a database from the results of the study.

EXPERIENCE

Lamprey Health Care, Nashua, New Hampshire
Chief Medical Officer ***May 2018-Present***
Nashua Site Medical Director ***August 2012-May 2018***
Family Physician ***August 2008-Present***

Southern New Hampshire Medical Center/Foundation Medical Partners, Nashua, New Hampshire
Hospitalist ***Jan 2009 - Present***

EHA Consulting Group, Inc.
Infectious Disease Epidemiologist ***Jan 2004 – June 2006***

- Epidemiology: Offered specialized consultation, remediation, interaction with regulatory agencies and expert testimony. Assessing and managing risks, corporate crisis intervention and allocating liabilities.
- Food Safety: Provide services in the areas of investigation, planning, compliance, education, and crisis management.

VASUKI NAGARAJ M.D., M.P.H. [redacted]

- Indoor air and mold: Provides strategies for the identification and resolution of problems involving Toxic Molds (Bioaerosols) and Indoor Air Quality (IAQ), including bioterrorist agents.

Chigateri General Hospital, *Intern* ***Apr 2000 – Apr 2001***

- Rotation Internship for a duration of one year in all departments.
- Responsible for inpatient care on the wards, making decisions independently, ensuring timely investigations/interventions and assisting in surgical procedures whenever necessary.
- Participated in ambulatory clinics/community health check ups, immunization programs and development of peripheral health centers.
- Worked for a period of three months during the Internship in rural and underdeveloped areas.

RESIDENCY **Central Maine Medical Center, Lewiston, ME** ***July 2005–June 2008***

A 250 – bed non profit hospital

- Gained hands on experience in patient care of children, adolescents, adults, older adults, pregnant women and acute care/ emergency settings.
- Responsible for independently evaluating and treating patients in the Outpatient Family Medicine Clinic, ordering labs, scheduling follow ups and performing necessary procedures in a timely fashion.
- Responsible for inpatient care on the floors, making decisions independently, ensuring timely investigations/interventions and assisting in surgical procedures whenever necessary.
- Responsible for teaching and supervising interns, and third/ fourth year medical students.
- Member of residency curriculum committee and Residency didactics committee

Co-chief Resident, Family Practice Residency, March 2007 – June 2008

- Work to enhance communication between the resident staff, the attending staff/faculty, and the technical staff.
- Advocate for the resident staff and promotes resident interests in conjunction with program needs and functions.
- Formulate resident rotation schedules, resident orientation programs, resident social functions, resident applicant interviews, and resident morale issues.

VASUKI NAGARAJ M.D., M.P.H. [redacted]

STANDARDIZED TESTS

- USMLE Step 1 Passed 08/03
- USMLE Step 2 CS Passed 01/04
- USMLE Step 2 CK Passed 02/04
- USMLE Step 3 Taken 03/07

LICENSURE/BOARD CERTIFICATION

Licensed in Maine during Residency EC-05-041
Licensed in New Hampshire
American Board of Family Medicine

REFERENCES

Available on request

Sue Durkin

[redacted]

Lamprey Health Care October 2018 – Present

Chief of Clinical Services June 2019 – Present
Provide oversight of operations and quality within all clinical services including primary care, prenatal care, behavioral health, Medication Assisted Treatment (MAT), Breast and Cervical Cancer Program (BCCP), diabetes education, care coordination and psychiatry. Responsible for program development; preparing grant applications and reports; and assuring compliance with state, federal, and funding requirements within these programs. Provide oversight of the quality department, risk management, and NCQA Patient Centered Medical Home recognition process. Oversee the activities of the safety committee and the emergency preparedness plan.

Director of Quality Improvement and Population Health October 2018 – June 2019
Responsible for the overall leadership and administration of the performance improvement and quality program of the organization, including: supported the Board of Director's strategic organizational initiatives; developed appropriate strategies for evidence based practices for improving clinical operations and outcomes measures related to Uniform Data Systems (UDS) and NCQA Patient Centered Medical Home.

Families First Health and Support Center September 1998 – August 2019

Clinical Director January 2015 – August 2019
Responsible for the development and oversight of all clinical programs including primary care, Health Care for the Homeless, prenatal, well child, Medication Assisted Treatment (MAT), care coordination, Breast and Cervical Cancer Program (BCCP), Hepatitis C treatment, and the integration of psychiatry within primary care. Oversaw quality improvement, reporting, risk management, policy development, systems development and management. Assured compliance with state and federal regulations. Facilitated training and staff development. Developed and maintained interagency collaborations. Participated in the organization's management team, NCQA Patient Centered Medical Home work group, and the quality improvement committee of the Board of Directors. Participated in grant development and management.

Health Care for the Homeless Program Director May 2011- January 2015
Provided overall organization, management, and delivery of quality patient care for the program. Supervised staff. Participated in the organization's management team.

Health Care for the Homeless Program Nurse September 2005 - May 2011
Provided primary nursing care to homeless patients in a mobile health setting.

Quality Improvement Director June 2001 - September 2011
Responsible for the organization's quality improvement program. Coordinated activities of the quality improvement committee of the Board of Directors.

Clinical Operations Director September 1998 - June 2001
Provided oversight of clinical operations for the health center. Responsible for the organization's quality improvement program. Participated in grant proposal development and reporting. Responsible for clinical staffing and supervision.

Wentworth-Douglass Hospital June 1997 - April 1999
Staff Nurse/Charge Nurse/Per Diem Nurse
Provided primary nursing care to pediatric, adolescent, and adult patients. Performed and assisted in outpatient procedures. Assumed charge nurse responsibilities as of November 1997.

Education:
Rivier College--St. Joseph's School of Nursing September 1995 - May 1997
A.D. Nursing, GPA 4.0

College of the Holy Cross September 1987 - May 1991
B.A. Sociology

Certifications/ Licenses:
Certified Profession in Healthcare Quality (CPHQ)
Registered Nurse in State of NH (RN)
Certified Asthma Educator (AE-C)
CPR Certified
Certified Yoga Teacher (RYT 200)

Boards of Directors:
Seacoast Women's Giving Circle 2016 – Present
Prescott Park Arts Festival 2005- 2007

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Gregory White	Chief Executive Officer	213,696.60	0	0
Evalie Crosby	Chief Financial Officer	161,549.44	0	0
Vasuki Nagaraj	Medical Director	265,137.34	0	0
Susan Durkin	Chief of Clinical Services	139,720.88	0	0

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-02)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Manchester Health Department		1.4 Contractor Address 1528 Elm St. Manchester, NH 03101	
1.5 Contractor Phone Number (603) 624-6466	1.6 Account Number 05-95-90-902010-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $412,006
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature Joyce Craig Date: 5/27/22		1.12 Name and Title of Contractor Signatory Joyce Craig Mayor	
1.13 State Agency Signature DocuSigned by: Patricia M. Tilley 848F838F58FD4C8... Date: 6/1/2022		1.14 Name and Title of State Agency Signatory Patricia M. Tilley Director	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Takhmina Rakhmatova FDF521C625C34AC...		On: 6/2/2022	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

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Date 5/27/22

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

Contractor Initials JC
Date 5/27/22

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

Contractor Initials JC
Date 5/27/22

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Provide Targeted Outreach to Homeless Women, Children, and Adolescents, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Obesity Screening in Children and Adolescents, in accordance with Attachment #4; and

1.12.2. QI Project two (2): Adolescent Well-Care Visits, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibits C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.
6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.
7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.
8. Audits
    8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:
        8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.
        8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.
        8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.
    8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.
        8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.
    8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Manchester Health Dept.*

Budget Request for: *Primary Care Services*

Budget Period *Upon G&C Approval - 6/30/2022*

Indirect Cost Rate (if applicable) 3.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$8,838
2. Fringe Benefits	$2,651
3. Consultants	$4,420
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Occupancy	$0
Transportation	$0
Interpreter Services	$91
Dental	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$16,000
Total Indirect Costs	$480
TOTAL	**$16,480**

Contractor Initials GC

Date 5/27/22

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Manchester Health Dept.*

Budget Request for: *7/1/2022-6/30/2023*

Budget Period *SFY 6/30/2023*

Indirect Cost Rate (if applicable) 3.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$79,846
2. Fringe Benefits	$23,954
3. Consultants	$17,680
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$1,652
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$6,000
5.(d) Supplies - Medical	$6,000
5.(e) Supplies Office	$1,200
6. Travel	$2,500
7. Software	$5,761
8. (a) Other - Marketing/Communications	$1,500
8. (b) Other - Education and Training	$3,000
8. (c) Other - Other (specify below)	
Occupancy	$29,910
Transportation	$5,000
Interpreter Services	$5,000
Dental	$3,000
9. Subrecipient Contracts	$0
Total Direct Costs	$192,003
Total Indirect Costs	$5,760
TOTAL	**$197,763**

Contractor Initials JC

Date 5/27/22

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Manchester Health Dept.*

Budget Request for: *7/1/2023-6/30/2024*

Budget Period *SFY 6/30/2024*

Indirect Cost Rate (if applicable) 3.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$79,846
2. Fringe Benefits	$23,954
3. Consultants	$17,680
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$1,652
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$6,000
5.(d) Supplies - Medical	$6,000
5.(e) Supplies Office	$1,200
6. Travel	$2,500
7. Software	$5,761
8. (a) Other - Marketing/Communications	$1,500
8. (b) Other - Education and Training	$3,000
8. (c) Other - Other (specify below)	
Occupancy	$29,910
Transportation	$5,000
Interpreter Services	$5,000
Dental	$3,000
9. Subrecipient Contracts	$0
Total Direct Costs	$192,003
Total Indirect Costs	$5,760
TOTAL	**$197,763**

Contractor Initials JC

Date 5/27/22

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by subparagraph 1.1.
   - 1.4. Notifying the employee in the statement required by subparagraph 1.1 that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Contractor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

New Hampshire Department of Health and Human Services
Exhibit E

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

New Hampshire Department of Health and Human Services
Exhibit G

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

Business Associate Use and Disclosure of Protected Health Information.

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

NH DHHS	City of Manchester Health Department
The State	Name of the Contractor
DocuSigned by: Patricia M. Tilley 84CF836F55ED4C8...	Joyce Craig
Signature of Authorized Representative	Signature of Authorized Representative
Patricia M. Tilley	Joyce Craig
Name of Authorized Representative	Name of Authorized Representative
Director	Mayor
Title of Authorized Representative	Title of Authorized Representative
6/1/2022	5/27/22
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $30,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $30,000 or more. If the initial award is below $30,000 but subsequent grant modifications result in a total award equal to or over $30,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique Entity Identifier (SAM UEI; Formerly DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

5/27/22
Date

Joyce Craig
Name: Joyce Craig
Title: Mayor

New Hampshire Department of Health and Human Services
Exhibit J

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The UEI (SAM.gov) number for your organization is: 790913636

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO X YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:

    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.

    b. safeguard this information at all times.

    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.

    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 – Screening for Referrals and SDOH

Enabling Services Work Plan Agency Name: Manchester Health Dept. Name and Role of Person(s) Completing Work Plan:			
Enabling Services Focus Area: 3.2.8.1 Screening and Referrals for SDOH			
Project Goal: Identify and address SDOH barriers to improve patients' access to integrated health care and to increase the rate of positive medical and behavioral health outcome achievement			
Project Objective: Achieve rate of CCSA process (SDOH screening) completion of 65% by 12/31/2022 in women and adolescents, based on current 2022 YTD CCSA completion rate of 49% for all patients (no women/adolescent-specific baseline available)			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Develop separate adult and adolescent CCSA process workflows Create Vizio document to record each CSSA process workflow	• Leadership Team • Program Director • Practice Manager • Behavioral Health Coordinator • Clinical Coordinator • Office Coordinator • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst (HISA) • Tablets/Laptops for EMR access • Vizio Access • Zoom Access • Leadership Team • HISA • Tablets/Laptops for EMR access	Completion of separate adult and adolescent workflow development Completion ofVizio documents: • Adult workflow • Adolescent workflow	07/31/2022 07/31/2022

Contractor Initials JC

Date 5/27/22

Attachment #1 – Screening for Referrals and SDOH

	• Vizio Access • Zoom Access		
Train appropriate existing staff on changes to the current CCSA process	• Leadership Team • QA Coordinator • HISA • Tablets/Laptops for EMR access • Vizio Access • Zoom Access	# of appropriate existing staff trained % of appropriate existing staff trained	09/30/2022
Develop training on CCSA process workflows and documentation for new staff	• Leadership Team • QA Coordinator • HISA • CHAN • Tablets/Laptops for EMR access • Vizio Access • Zoom Access	Completion of CCSA process training development	08/30/2022
Conduct CCSA process training during onboarding period for all appropriate new staff	• Leadership Team • QA Coordinator • HISA • Tablets/Laptops for EMR access • Vizio Access • Zoom Access	# of appropriate new staff who completed CCSA process training by 90 day evaluation % of appropriate new staff who completed CCSA process training by 90 day evaluation	Ongoing through 12/31/2022
Generate separate screening packets for patients 12-17 and patients 18-21	• Leadership Team • Transition of Care staff • Patient Service Representatives • QA Coordinator • HISA • Vizio Access • Zoom Access	Completion of separate screening packet creation	08/31/2022

Attachment #1 – Screening for Referrals and SDOH

Implement new CCSA processes in all HCH service lines	• Leadership Team • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs)	# of adolescent CCSAs initiated # of women's CCSAs initiated	12/31/2022
	• Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Tablets/Laptops for EMR access • Vizio Access Zoom Access		
Create CCSA Completion Report targeting women and adolescents	• Leadership Team • QA Coordinator • HISA • Tablets/Laptops for EMR access • Community Health Access Network (CHAN) • SAP Business Web Intelligence Access • Vizio Access • Zoom Access	Completion of report development	12/31/2022
Transitions of Care Coordinators (ToCCs) to run CCSA Completion Reports and distribute results weekly	• Leadership Team • Transition of Care staff • QA Coordinator • HISA • Tablets/Laptops for EMR access • CHAN • SAP Business Web Intelligence Access	# weekly reports distributed	12/31/2022

Attachment #1 – Screening for Referrals and SDOH

Leadership Team to monitor report monthly and collaborate to identify and address challenges	• Leadership Team • QA Coordinator • HISA • Tablets/Laptops for EMR access • Vizio Access • Zoom Access	Addition of CCSA Completion Report review into Leadership Team meeting agenda as item recurring monthly	12/31/2022
Monitor report results to identify staff who would benefit from additional training in the CCSA process and its documentation	• Leadership Team • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • HISA • Tablets/Laptops for EMR access • CHAN • Zoom Access	# of established staff identified for additional training on CCSA process implementation and documentation	12/31/2022
QA Coordinator HISA to complete random chart audits to identify patterns of issues resulting in incomplete CCSA process	• QA Coordinator • HISA • Tablets/Laptops for EMR access • CHAN • SAP Business Web Intelligence Access • Vizio Access • Zoom Access	# of audits completed	12/31/2022

Attachment #1 – Screening for Referrals and SDOH

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** Yes No	
January 2023 Progress Report- • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** Yes No	

Attachment #1 – Screening for Referrals and SDOH

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).		
Did you meet your Target/Objective?	Yes	No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** ___ Yes ___ No		
July 2023 Project Update **SFY23 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.		
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for		

Attachment #1 – Screening for Referrals and SDOH

review and/or approval. **Work Plan Revisions submitted:** Yes No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story:** Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

Enabling Services Work Plan Agency Name: Manchester Health Dept. Name and Role of Person(s) Completing Work Plan:			
Enabling Services Focus Area: 3.2.8.2.6 Providing targeted outreach to homeless women, children, and adolescents			
Project Goal: Increase access to integrated health care services to homeless women, children, and adolescents			
Project Objective: Increase the number of mobile van outreach sites targeting homeless women, children, and adolescents from current baseline of 0 sites to 2 sites by December 31, 2022.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Identify agencies who serve the target population (homeless women, children, and adolescents) interested in being a mobile care van outreach site	• Leadership Team • Program Director • Practice Manager • Behavioral Health Coordinator • Clinical Coordinator • Office Coordinator • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway	# of partner agencies surveyed # of interested partner agencies	05/31/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	• CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops • Zoom Access		
Collaborate with community outreach teams to identify geographic areas of need in which a high proportion of women are staying in encampments	• Leadership Team • Program Director • Practice Manager • Behavioral Health Coordinator • Clinical Coordinator • Office Coordinator • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery	# of partner agencies surveyed # of potential locations identified	06/30/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	• Manchester Community Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops Zoom Access		
Evaluate potential sites to determine which would target homeless women, children, and adolescents most effectively; choose which locations to actively pursue as mobile van outreach sites	• Leadership Team • Program Director • Practice Manager • Behavioral Health Coordinator • Clinical Coordinator • Office Coordinator • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery • Manchester Community	# of potential sites assessed to target homeless women, children, and adolescents # of sites actively pursued as mobile van outreach sites	07/31/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops • Zoom Access		
Establish agreements with partnering agencies who agree to be a mobile van outreach site	• Leadership Team • CMC Community Services Director • ***** Do we have to have formal agreements that other CMC admin departments have to be involved with? • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops • Zoom Access	# of partner agreements finalized # of outreach sites established with partnering agencies	09/30/2022
Set schedule for mobile van outreach at new sites	• Leadership Team • Clinical Team (Nurses, CMAs) • Behavioral Health Team	Completion of mobile van outreach schedule	10/30/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	• Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops • Zoom Access		
Implement targeted outreach plan at identified sites	• Leadership Team • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269	# of targeted outreach visits	11/30/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

		# of homeless women served at outreach sites	
		# of homeless children served at outreach sites	
		# of homeless adolescents served at outreach sites	

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	• International Institute • The Doorway • CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls Club • Manchester School District • MCoC • The Way Home • Tablets/Laptops • Zoom Access		
Monitor sites to ensure outreach remains targeted to homeless women, children, and adolescents	• Leadership Team • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls Club • Manchester School District	# of visits at outreach sites that meet target population criteria % of visits at outreach sites that meet target population criteria	12/31/2022

Attachment #2 – Providing Targeted Outreach to Homeless Women, Children, and Adolescents

	• MCoC • The Way Home • Tablets/Laptops Zoom Access		
Reengage in site identification process should any site become ineffective in reaching target population	• Leadership Team • Program Director • Practice Manager • Behavioral Health Coordinator • Clinical Coordinator • Office Coordinator • Transition of Care staff • Patient Service Representatives • Clinical Team (Nurses, CMAs) • Behavioral Health Team • Street Medicine medical providers • QA Coordinator • Health Information Systems Analyst • Community Partner Agencies • FIT • MHCGM • Waypoint • 1269 • International Institute • The Doorway • CMC Roots for Recovery • Manchester Community Resource Center • Boys and Girls **Club** • Manchester School District • MCoC	# of sites determined to no longer target homeless women, children, and adolescents # of new potential sites identified # of new sites established	12/31/2022

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023)	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 (July 1, 2023 - June 30, 2024)	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

Attachment #4 – Obesity Screening in Children and Adolescents

Quality Improvement Work Plan 1 Agency Name: Manchester Health Dept. Name and Role of Person(s) Completing Work Plan: Danielle Provencal, Practice Manager			
MCH Performance Measure: Preventative Health, Adolescent Well-Care Visit: Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDI$).			
Project Objective: The HCH Manchester Program seeks to increase the percent of patients, ages 12 through 21 years of age (5% of total 2021 HCH population) that will have received their annual Well-Care Visit within the calendar year (CY) from 20% to 50% by January 1st, 2023.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Fill any vacancies of listed personnel for this performance measure work plan: 1. Vacancy for one RN Care Coordinator (40 Hours/1 FTE) 2. Vacancy for one PSR-Scheduling Coordinator (40 Hours/1 FTE)	CMC Human Resources Recruiter and Practice Manager to review all applicants. 1. HCH Lead RN Care Coordinator will interview any qualified applicants and select for hire in conjunction with Practice Manager. 2. HCH Office Coordinator will interview any qualified applicants and select for hire in conjunction with Practice Manager.	Any delays in progress for applicant hire will be communicated and attended to in real time between the staff involved.	Positions expected to be filled by July 1st, 2022.
Report Identification: 1. Completed Well-Care Visits of patients 12 through 21 years of age. - To include patient name, patient PCP and date of Well-	HCH Health Information Systems Analyst to work with the Community Health Access Network (CHAN) to ensure the identified reports are available on the CHAN Report Server.	Practice Manager to follow up with HCH Health Information Systems Analyst weekly to check in on progress.	Reports to be available by July 1st 2022.

Attachment #4 – Obesity Screening in Children and Adolescents

Care Visit. 2. Patients 12 through 21 years of age who have not had a completed Well-Care Visit within the calendar year (CY). - To include patient name, patient PCP and date of Well-Care Visit. - To include last visit, last no show, next visit. 3. Master Panel Report of patients 12 through 21 years of age. - Patient Name - PCP - Completed CPE (Y/N) - Completed PHQ9 (Y/N) - Completed SBIRT (Y/N)			
Workflow development on scheduling Well-Care Visits/CPE.	Office Coordinator-PSR to develop workflow for training PSR-Scheduling Coordinators on evaluating if CPE needs to be scheduled and a routine of scheduling CPEs for all patients.	Practice Manager to check-in with Office Coordinator-PSR weekly to ensure barriers for completion are evaluated and attended to.	August 1st, 2022
Workflow development on integrating Behavioral Health into annual Well-Care Visits/CPE. I.E. Corresponding availability of BH Clinician for scheduled Well-	Behavioral Health Coordinator to evaluate current screening tool(s) and develop and needed improvements to corresponding workflows for screeners and	Practice Manager to check-in with Behavioral Health Coordinator weekly to ensure barriers for completion are evaluated and attended to.	August 1st, 2022

Attachment #4 – Obesity Screening in Children and Adolescents

Care Visits/CPE for any elevated screenings during the appointment.	accounting in the EMR. Once developed, offer all staff training on screening tools and process.		
Workflow development on checking Protocols and Patient Education on importance of scheduling Well-Care Visits/CPE.	Lead RN Care Coordinator to develop workflow for training nurses and medical assistants on: 1. Checking protocols to ensure a CPE is scheduled within the measurement year. 2. Scripting and tips on patient education to ensure patients understand the importance of completing their annual Well-Care Visit/CPE.	Practice Manager to check-in with Lead RN Care Coordinatorto ensure barriers for completion are evaluated and attended to.	August 1", 2022
Workflow development on vaccine management that coincides with a patient's Well-Care Visit/CPE.	Lead RN Care Coordinator to develop workflow for all areas of vaccine administration and management to cross train the nursing and medical assistant team.	Lead RN Care Coordinator to run reports on overdue vaccines and work with RN Care Coordinators on outreach to patients and aligning with upcoming visits.	August 1st, 2022
Lead RN Care Coordinator and Office Coordinator-PSR to be trained in running Well-Care Visits (CPE) report and distribute monthly to their staff for review and scheduling.	HCH Health Information Systems Analyst and Practice Manager to review report and implement training for Lead RN Care Coordinator and Office Coordinator-PSR.	Practice Manager to evaluate any barriers to completing training and assist in evaluating workflow concerns and questions.	September 1st, 2022
Identify Barriers to Care: 1. Drill down and review patient cases where the Well-Care Visit was not completed.	HCH Quality Improvement Specialist, Lead RN Care Coordinator, Behavioral Health Coordinator and Office Coordinator-PSR to:	HCH Quality Improvement Specialist, Lead RN Care Coordinator and Office Coordinator-PSR to meet quarterly on progress and	November 1st, 2022 & ongoing.

Attachment #4 – Obesity Screening in Children and Adolescents

2. Case review and care plan development. 3. Identify resources for barrier reduction.	1. Review barriers 2. Identify workflow development needs. 3. Identify additional **resource needs, i.e.** transportation, schedule blocks, patient/family education, staff trainings.	advance any ongoing barriers to Practice Manager for review and supports.	

Attachment #4 – Obesity Screening in Children and Adolescents

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-6/30/23)	

Attachment #4 – Obesity Screening in Children and Adolescents

Did you meet your Target/Objective?	Yes	No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** Yes No		
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** Yes No		
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)		
Did you meet your Target/Objective?	Yes	No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year		

Attachment #5 – Adolescent Well-Care Visits

Quality Improvement Work Plan 2 Agency Name: Manchester Health Dept. Name and Role of Person(s) Completing Work Plan: Danielle Provencal, Practice Manager			
MCH Performance Measure: Preventative Health, Obesity Screening in Child/Adolescent: Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).			
Project Objective: The HCH Manchester Program seeks to increase the percent of patients who have a documented BMI percentile, a documentation of counseling for nutrition anddocumentation of counseling for physical activity during a medical visit in the measurement year from 73%to 80%by January 1st, 2023 in patients 3 years of age through 16 years of age (6% of total 2021 HCH patient population).			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Fill any vacancies of listed personnel for this performance measure work plan: 1. Vacancy for one RN Care Coordinator (40 Hours/1 FTE)	CMC Human Resources Recruiter and Practice Manager to review all applicants. 1. HCH Lead RN Care Coordinator will interview any qualified applicants and select for hire in conjunction with Practice Manager.	Any delays in progress for applicant hire will be communicated and attended to in real time between the staff involved.	Positions expected to be filled by July 1st, 2022.
Report Identification: 1. Patients age =>3 to <=17 with Medical Visit within calendar year 2022. - Patient Name - PCP - Last Medical Visit - Next Appt - Date Last BMI% - Last BMI - Date Counseled - Counseling Outcome	HCH Health Information Systems Analyst to work with the Community Health Access Network (CHAN) to ensure the identified report is available on the CHAN Report Server.	Practice Manager to follow up with HCH Health Information Systems Analyst weekly to check in on progress.	Reports to be available by July 1st 2022.

Attachment #5 – Adolescent Well-Care Visits

- Up to Date (UTD) (Y/N)			
Review current workflow and establish EMR documentation guides.	Lead RN Care Coordinator and HCH Quality Improvement Specialist to review current workflow and develop workflow and EMR guide for proper documentation of BMI percentile, counseling for nutrition and physical activity in the EMR.	Practice Manager to check in weekly until completion to identify barriers and support needs.	July 1st, 2022
Training of all clinical staff on workflow and proper documentation in the EMR.	Lead RN Care Coordinator and HCH Quality Improvement Specialist to host training for all clinical staff on workflow review and proper documentation.	Delays in scheduling all clinical staff training and barriers for completion to be reported to Practice Manager in real time.	Training to be completed August 1st, 2022.
Report Running & Audit	Lead RN Care Coordinator and Practice Manager to run report monthly to monitor progress and identify any additional training needs.	10 charts to be reviewed/audited monthly by Lead RN Care Coordinator.	Audits to start by September 1st, 2022.
Competency Development: 1. BMI calculation and percentage development. 2. Counseling on nutrition. 3. Counseling on physical activity.	Lead RN Care Coordinator to ensure these competencies are included in clinical staff annual competency evaluation. Develop and identify training resource needs.	Lead RN Care Coordinator to collaborate with Medical Director and Practice Manager on development and roll out. Report out any delays or barriers in completion.	To be included in annual November 2022 competency review.
Identify Barriers to Care: 1. Drill down and review patient cases where the Well-Care Visit was not completed. 2. Case review and care	HCH Quality Improvement Specialist and Lead RN Care Coordinator to: 1. Review barriers 2. Identify workflow development needs.	HCH Quality Improvement Specialist and Lead RN Care Coordinator to meet quarterly on progress and advance any ongoing barriers to Practice Manager for review and	November 1st, 2022 & ongoing.

Attachment #5 – Adolescent Well-Care Visits

plan development. 3. Identify resources for barrier reduction.	3. Identify additional resource needs, i.e. transportation, schedule blocks, patient/family education, staff trainings.	supports.	

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	

Attachment #5 – Adolescent Well-Care Visits

January 2023 Progress Report- • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** Yes No	
July 2023 Project Update **SFY23 Outcome** (insert your agency's data/outcome results here for 7/1/22-	

Attachment #5 – Adolescent Well-Care Visits

6/30/23)	
Did you meet your Target/Objective?	Yes No
July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success If NOT met-what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** Yes No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** Yes No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	Yes No
July 2024 Project Update **SFY24 Narrative:** If met--Explain what happened during the year that contributed	

Attachment #5 – Adolescent Well-Care Visits

to the success If NOT met-what barriers were experienced, what will be done differently to meet the target over the next year	

New Hampshire Department of Health and Human Services
Maternal Child Health in the Integrated Primary Care Setting

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. Breastfeeding

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. Preventive Health: Lead Testing

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

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Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

Attachment #6 – Performance Measures

and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

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Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

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Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

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5/7/13

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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9/27/13

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

QC
5/27/22

CERTIFICATE OF VOTE

I, Matthew Normand, do hereby certify that:
(Name of the City Clerk of the Municipality)

1. I am duly elected City Clerk of the City of Manchester

2. The following is a true copy of an action duly adopted at a meeting of the Board of Mayor and Aldermen duly held on May 17, 2022.

RESOLVED: That this Municipality enter into a contract with the State of New Hampshire, Department of Health and Human Services.

RESOLVED: That Joyce Craig,
(Mayor of the City of Manchester)
hereby is authorized on behalf of this municipality to enter into the said contract with the State and to execute any and all documents, agreements, and other instruments; and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable, or appropriate.

3. The foregoing action on has not been amended or revoked and remains in full force and effect as of May 17, 2022

4. Joyce Craig (is/are) the duly elected Mayor of the City of Manchester.

Matthew Normand
(Signature of the Clerk of the Municipality)

State of New Hampshire
County of Hillsborough

The foregoing instrument was acknowledged before me this 1st day of June, 2022 by Matthew Normand.
(Name of Person Signing Above)

(NOTARY SEAL)

Lisa McCarthy
(Name of Notary Public)

Title: Notary Public/Justice of the Peace
Commission Expires: LISA M. MCCARTHY
NOTARY PUBLIC
State of New Hampshire
My Commission Expires
June 24, 2025

Kevin J. O'Neil
Risk Manager

CITY OF MANCHESTER

Office of Risk Management

CERTIFICATE OF COVERAGE
STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
129 Pleasant Street
Concord, New Hampshire 03301-3857

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage within the financial limits of RSA 507-B as follows:

	Limits of Liability (in thousands 000)	
GENERAL LIABILITY	Bodily Injury and Property Damage	
	Each Person	325
	Each Occurrence	1000
AUTOMOBILE LIABILITY	Bodily Injury and Property Damage	
	Each Person	325
	Each Occurrence	1000
WORKER'S COMPENSATION	Statutory Limits	

The City of Manchester, New Hampshire maintains a Self-Insured, Self-Funded Program and retains outside claim service administration. All coverages are continuous until otherwise notified. Effective on the date Certificate issued and expiring upon completion of contract. Notwithstanding any requirements, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the coverage afforded by the limits described herein is subject to all the terms, exclusions and conditions of RSA 507-B.

DESCRIPTION OF OPERATIONS/LOCATION/CONTRACT PERIOD
For the Manchester Health Department Primary Care Services Grant from April 1, 2022 to June 30, 2024.

Issued the 5th day of May, 2022.

Kevin O'Neil, RMO
Kevin O'Neil, Risk Manager

One City Hall Plaza • Manchester, New Hampshire 03101 • (603) 624-6503 • FAX: (603) 624-6528
TTY: 1-800-735-2964
E-Mail: koneil@manchesternh.gov • Website: www.manchesternh.gov

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-08)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mid-State Health Center		1.4 Contractor Address 101 Boulder Point Dr. Suite #1 Plymouth, NH 03264	
1.5 Contractor Phone Number (603) 536-4000	1.6 Account Number 05-95-90-90210-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $640,823
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Robert MacLeod Date: 5/17/2022		1.12 Name and Title of Contractor Signatory Robert MacLeod CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt Date: 5/18/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino		On: 5/20/2022	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

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Date 5/17/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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Date 5/17/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Postpartum Care for Women, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Preventative Health: Adolescent Well-Care Visits, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Obesity Screening-Child/Adolescent Measure, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

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1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

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license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Mid-State Health Center*

Budget Request for: *Primary Care Services*

Budget Period *date of G&C – 6/30/22*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$ 18,205.25
2. Fringe Benefits	$ 5,097.47
3. Consultants	$ -
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$ -
5.(a) Supplies - Educational	$ -
5.(b) Supplies - Lab	$ -
5.(c) Supplies - Pharmacy	$ -
5.(d) Supplies - Medical	$ -
5.(e) Supplies Office	$ -
6. Travel	$ -
7. Software	$ -
8. (a) Other - Marketing/Communications	$ -
8. (b) Other - Education and Training	$ -
8. (c) Other - Other (specify below)	
Other (please specify)	$ -
Other (please specify)	$ -
Other (please specify)	$ -
Other (please specify)	$ -
9. Subrecipient Contracts	$ -
Total Direct Costs	$ 23,302.73
Total Indirect Costs	$ 2,330.27
TOTAL	$ **25,633.00**

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Contractor Initials

5/17/2022
Date

New Hampshire Department of Health and Human Services	
Complete one budget form for each budget period.	
Contractor Name:	*Mid-State Health Center*
Budget Request for:	*Primary Care Services*
Budget Period	*July 1, 2022 - June 30, 2023 (State Fiscal Year 2023)*
Indirect Cost Rate (if applicable)	10.00%

Line Item	Program Cost - Funded by DHHS	
1. Salary & Wages	$	199,460.23
2. Fringe Benefits	$	55,848.86
3. Consultants	$	-
4. Equipment:	$	10,475.00
5.(a) Supplies - Educational	$	1,500.00
5.(b) Supplies - Lab	$	-
5.(c) Supplies - Pharmacy	$	4,800.00
5.(d) Supplies - Medical	$	4,875.00
5.(e) Supplies Office:	$	300.00
6. Travel	$	-
7. Software	$	-
8. (a) Other - Marketing/Communications:	$	1,625.00
8. (b) Other - Education and Training:	$	1,000.00
8. (c) Other - Other (specify below)		
Other: Incentives - Transportation - Gas Cards	$	700.00
Other (please specify)	$	-
Other (please specify)	$	-
Other (please specify)	$	-
9. Subrecipient Contracts	$	-
Total Direct Costs	$	280,584.09
Total Indirect Costs (10%)	$	27,010.91
TOTAL	**$**	**307,595.00**

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Contractor Initials

5/17/2022
Date

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Mid-State Health Center*

Budget Request for: *Primary Care Services*

Budget Period *July 1, 2023 - June 30, 2024 (State Fiscal Year 2024)*

Indirect Cost Rate (if applicable) 10.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$ 207,425.92
2. Fringe Benefits	$ 58,080.90
3. Consultants	$ -
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$ -
5.(a) Supplies - Educational	$ 2,250.00
5.(b) Supplies - Lab	$ -
5.(c) Supplies - Pharmacy	$ 2,000.00
5.(d) Supplies - Medical	$ 6,375.00
5.(e) Supplies Office	$ 500.00
6. Travel	$ -
7. Software	$ -
8. (a) Other - Marketing/Communications	$ 1,000.00
8. (b) Other - Education and Training	$ 1,000.00
8. (c) Other - Other (specify below)	
Other: Incentives - Transportation - $10 Gas Cards	$ 1,000.00
Other (please specify)	$ -
Other (please specify)	$ -
Other (please specify)	$ -
9. Subrecipient Contracts	$ -
Total Direct Costs	$ 279,631.82
Total Indirect Costs	$ 27,963.18
TOTAL	**$ 307,595.00**

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Contractor Initials

5/17/2022

Date

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

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Vendor Initials _____

5/17/2022
Date _____

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

5/17/2022
Date

DocuSigned by:
Robert MacLeod
0CA80BE0385A4B8...
Name: Robert MacLeod
Title: CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/17/2022
Date

DocuSigned by:
Robert MacLeod
Name: Robert MacLeod
Title: CEO

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Vendor Initials
5/17/2022
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials PM (DS)
Date 5/17/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/17/2022
Date

DocuSigned by:
Robert MacLeod
0CA568E80B5A400...
Name: Robert MacLeod
Title: CEO

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PM
Contractor Initials

5/17/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:
Robert MacLeod
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5/17/2022
Date

Name: Robert MacLeod
Title: CEO

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:
Robert MacLeod

5/17/2022
Date

Name: Robert MacLeod
Title: CEO

DS
PM
Contractor Initials

5/17/2022
Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) **Definitions**.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

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l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

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Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) Obligations and Activities of Business Associate.

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Contractor Initials PM

Date 5/17/2022

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Mid State Health Center
The State	Name of the Contractor
Docusigned by: Iain Watt D7788B63F9704C7...	DocuSigned by: Robert MacLeod 0CA008E0963A490...
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Robert MacLeod
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	CEO
Title of Authorized Representative	Title of Authorized Representative
5/18/2022	5/17/2022
Date	Date

New Hampshire Department of Health and Human Services
Exhibit J

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Robert MacLeod

5/17/2022
Date

Name: Robert MacLeod
Title: CEO

DS
PM

Contractor Initials
5/17/2022
Date

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 109385625

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.
2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 - Screening and Referrals for SDOH

Enabling Services Work Plan
Agency Name: **Mid-State Health Center**
Name and Role of Person(s) Completing Work Plan: **Debbie Guilbert, QI Coordinator**

Enabling Services Focus Area: ***Improved Screening and Referrals for SDOH***

Project Goal: ***Connect patients with enabling services to improve health outcomes.***

Project Objective: ***Increase the number of patients who complete SDOH screening and improve continued support efforts for patients identified with needs***

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Strategic marketing to encourage patients to complete SDOH survey prior to appointment.	Marketing Manager Patient Engagement Platform Quality Improvement Team Patient Services	Current SDOH survey completion is 15% of patients seen in 2021. Goal to increase this by 10%. QI Dept will measure results	July 2022 - ongoing
Connect with area resources for women, children and families to create formal referral processes for identified needs.	Community Health Worker Integrated Healthcare Coordinator Patient Navigators	Current Resource database has 33 area resources. The goal will be to increase this list by 50%. QI department will track growth.	April 2022 - ongoing
Evaluate current and potential patient engagement platforms adaptability and ease of use.	QI Coordinator Data Steward Communications manager Finance Director	Current SDOH survey completion is 15% of patients seen in 2021. Goal to increase this by 10%. QI Dept will measure results	April 2022 – June 2022
Develop and implement program to track, follow-up, and re-evaluate those identified with needs.	QI Coordinator Data Steward Integrated Healthcare Coordinator Community Health Worker Patient Navigator	Care plan tracking	April 2022 - Ongoing

Contractor Initials PM (DS)
Date 5/17/2022

Attachment #1 - Screening and Referrals for SDOH

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: ***Improved Screening and Referrals for SDOH*** Project Objective: ***Increase the number of patients who complete SDOH screening and improve continued support efforts for patients identified with needs***	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Contractor Initials PM (OS)

Date 5/17/2022

Attachment #1 - Screening and Referrals for SDOH

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Contractor Initials DS PM

Date 5/17/2022

Attachment #1 - Screening and Referrals for SDOH

Work Plan Revisions submitted: _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Contractor Initials PM (DS)

Date 5/17/2022

Attachment #2 - Postpartum Care for Women

Enabling Services Work Plan Agency Name: **Mid-State Health Center** Name and Role of Person(s) Completing Work Plan: **Debbie Guilbert, QI Coordinator**			
Enabling Services Focus Area: ***Postpartum Care for Women***			
Project Goal: ***Improved services and outcomes for postpartum women and Infants***			
Project Objective: ***Develop and Implement services for women during the postpartum stage of pregnancy in order to improve outcomes related to postpartum depression, contraception, breastfeeding and infant safety and development.***			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Develop a team with physicians, APRNs, and Behavioral Health specialist to have focused appointments to address postpartum women's health	1-2 Physicians 2 APRN 2 BH Quality Dietician	Evaluate team for qualifications, knowledge, and experience with this work.	April 2022
Develop and implement "4th Trimester" outreach and care model to include regular outreach and visits during postpartum period. Look to include support with mental health, nutrition, breastfeeding, contraception, and infant safety and development.	Clinical Staff BH Staff Patient Navigator CHW Quality Team Marketing	Track and Report number of postpartum women, those that enroll in the program, and those who complete program, infant immunizations and screenings,	May 2022 – July 2022 planning phase Aug 2022 – Ongoing Implementation and evaluation phase
Develop and Implement Quick Start Contraception Program.	Clinical staff Finance Pharmacy		May 2022 – July 2022 planning Aug 2022 – ongoing – implement and evaluate

DS PM

Contractor Initials _____

5/17/2022

Date _____

Attachment #2 - Postpartum Care for Women

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: ***Postpartum Care for Women*** Project Objective: ***Develop and Implement services for women during the postpartum stage of pregnancy in order to improve outcomes related to postpartum depression, contraception, breastfeeding and infant safety and development.***	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Contractor Initials PM (DS)

Date 5/17/2022

Attachment #2 - Postpartum Care for Women

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

Contractor Initials PM

Date 5/17/2022

Attachment #2 - Postpartum Care for Women

Work Plan Revisions submitted: _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Contractor Initials DS PM

Date 5/17/2022

Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

DS PM

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

DS PM

5/17/2022

Attachment #4 - Preventative Health: Adolescent Well-Care Visit

Quality Improvement Work Plan Agency Name:
Mid-State Health Center
Name and Role of Person(s) Completing Work Plan:
Debbie Guilbert, QI Coordinator

MCH Performance Measure: ***Preventive Health: Adolescent Well-Care Visit***

Project Objective: ***To increase the number of adolescent patients seen for Well Care visits with a starting baseline of 41% to be increased to 75% by the end of the contract period with a goal of 18% growth each year.***

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Monthly Identification of patients in need of Well Care Visit	QI Team	QI team will track and report performance measures monthly: Adolescent Well Care Visits	April 2022 – ongoing
Regular outreach to patient/representative to schedule WC visits	Patient Services		April 2022 – ongoing

Contractor Initials PM (OS)
Date 5/17/2022

Attachment #4 - Preventative Health: Adolescent Well-Care Visit

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update	

Contractor Initials PM (DS)

Date 5/17/2022

Attachment #4 - Preventative Health: Adolescent Well-Care Visit

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	

Contractor Initials BM DS

Date 5/17/2022

Attachment #4 - Preventative Health: Adolescent Well-Care Visit

SFY24 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

Contractor Initials PM (DS)

Date 5/17/2022

Attachment #5 - Obesity Screening-Child/Adolescent Measure

Quality Improvement Work Plan Agency Name:
Mid-State Health Center
Name and Role of Person(s) Completing Work Plan:
Debbie Guilbert, QI Coordinator

MCH Performance Measure: ***Obesity Screening – Child/Adolescent Measure***

Project Objective: ***To increase the number of adolescent patients seen for Well Care visits with documented BMI along with nutrition and physical activity counseling from a baseline of 64% to be increased to 75% by the end of the contract period with a goal of 5% growth each year.***

Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Monthly Identification of patients in need of Well Care Visit	QI Team	QI team will track and report performance measures monthly: Adolescent Well Care Visits Child/Adolescent Obesity Screening	April 2022 – ongoing
Regular outreach to patient/representative to schedule WC visits	Patient Services		April 2022 – ongoing
Enhanced training to MA/clinicians for proper documentation of BMI with nutrition and physical activity counseling	QI team Medical assistants Clinicians Management team		April 2022 – ongoing
Develop and implement enhanced care plan for patients with BMI out pf range.	Physical Therapy Staff Dietician Clinician QI Team	QI team to track and measure patients meeting out of range measure and being referred for enhanced counseling	

Contractor Initials PM (DS)

Date 5/17/2022

Attachment #5 - Obesity Screening-Child/Adolescent Measure

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update	

Attachment #5 - Obesity Screening-Child/Adolescent Measure

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	

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PM
Contractor Initials _____
5/17/2022
Date _____

Attachment #5 - Obesity Screening-Child/Adolescent Measure

SFY24 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

Contractor Initials DS PM

Date 5/17/2022

Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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Attachment #6 – Performance Measures

and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

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Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

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Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

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Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

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State of New Hampshire

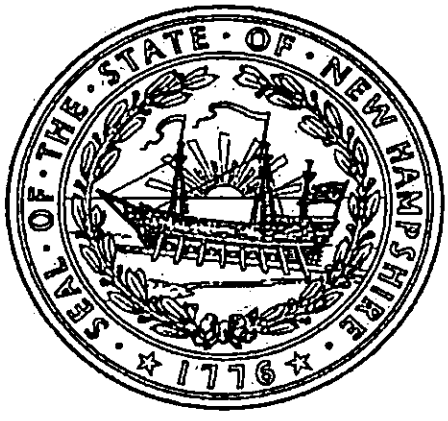
Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that MID-STATE HEALTH CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on January 09, 1998. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **285492**

Certificate Number: **0005779264**



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 18th day of May A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE OF AUTHORITY

I, Carina Park, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Mid-State Health Center.
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on April 26, 2022, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Robert MacLeod, (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Mid-State Health Center to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 4/26/22

Signature of Elected Officer
Name: Carina Park
Title: Board of Directors Secretary

DocuSign Envelope ID: 1D3A0AD7-9222-4BD0-B0B9-7046C72BE7D5

CERTIFICATE OF LIABILITY INSURANCE

Date: 09/10/21

Administrator:
New England Special Risks, Inc.
60 Prospect St.
Sherborn, Ma. 01770
Phone: (508) 561-6111

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policies below.

INSURERS AFFORDING COVERAGE

Insurer A:	Medical Protective Insurance Co.
Insurer B:	AIM Mutual Insurance Co.
Insurer C:	
Insurer D:	
Insurer E:	

Insured:
Mid-State Health Center
101 Boulder Point Dr.- Suite 1
Plymouth, NH. 03264

Coverages

The policies of insurance listed below have been issued to the insured named above for the policy period indicated. Notwithstanding any requirement, term or condition of any contract or other document with respect to which the certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies, aggregate limits shown may have been reduced by paid claims.

INS. LTR.	TYPE OF INSURANCE	POLICY NUMBER	Policy Effective Date	Policy Expiration Date	LIMITS		
A	**General Liability** ☑ Commercial General Liability ☐ Claims Made ☑ Occurrence ☐ ☐ General Aggregate Limit Applies Per: ☑ Policy ☐ Project ☐ Loc	HN 030313	10/1/2021	10/1/2022	Each Occurrence	$	1,000,000
					Fire Damage (Any one fire	$	50,000
					Med Exp (Any one person)	$	5,000
					Personal & Adv Injury	$	1,000,000
					General Aggregate	$	3,000,000
					Products - Comp/Op Agg	$	1,000,000
	Automobile Liability ☐ Any Auto ☐ All Owned Autos ☐ Scheduled Autos ☐ Hired Autos ☐ _____				Combined Single Limit (Each accident)	$	
					Bodily Injury (Per person)	$	
					Bodily Injury (Per accident)	$	
					Property Damage (Per accident)	$	
	Garage Liability ☐ Any Auto ☐				Auto Only - Ea. Accident	$	
					Other Than Auto Only: Ea. Acc	$	
					Other Than Auto Only: Agg	$	
	Excess Liability ☐ Occurrence ☐ Claims Made ☐ Deductible ☐ Retention $				Each Occurrence	$	
					Aggregate	$	
						$	
						$	
						$	
B	**Workers Compensation and Employers' Liability**	600-4000079-2021	10/1/2021	10/1/2022	☑ Statutory Limits ☐ Other		
					E.L. Each Accident	$	500,000
					E.L. Disease-Ea. Employee	$	500,000
					E.L. Disease - Policy Limit	$	500,000
A	**Healthcare Professional Liability**	HN 030313	10/1/2021	10/1/2022	Per Incident-$1,000,000 Aggregate-$3,000,000		

Description of operations/vehicles/exclusions added by endorsement/special provision

Evidence of Current Insurance for the Insured.

Certificate Holder

State of New Hampshire
Department of Health and Human Services
129 Pleasant St.
Concord, NH. 03301

Should any of the above policies be canceled before the expiration date thereof, the issuing insurer will endeavor to mail 10 days written notice to the certificate holder named to the left, but failure to do so shall impose no obligation or liability of any kind upon the insurer, its agents or representatives.

Authorized Representative

Emanuel Pinheiro

MID-STATE HEALTH CENTER

Where your care comes together.

Family, Internal and Pediatric Medicine • Behavioral Health • Dental Care

midstatehealth.org

Mission Statement: Mid-State Health Center provides sound primary medical care to the community, accessible to all regardless of the ability to pay.

Plymouth Office: 101 Boulder Point Drive • PH (603) 536-4000 • FAX (603) 536-4001
Bristol Office: 100 Robie Road • PH (603) 744-6200 • FAX (603) 744-9024
Mailing Address: 101 Boulder Point Drive • Suite 1 • Plymouth, NH 03264

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Financial Statements

As of and for the Years Ended
June 30, 2019 and 2018

Supplemental Schedule of Expenditures of Federal Awards

For the Year Ended June 30, 2019

and

Independent Auditors' Report

MID-STATE
HEALTH CENTER
A non-profit corporation

MID-STATE HEALTH CENTER AND SUBSIDAIRY

Table of Contents

As of and for the Years Ended June 30, 2019 and 2018

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Independent Auditors' Report

To the Board of Trustees of
Mid-State Health Center and Subsidiary:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mid-State Health Center and Subsidiary, which comprise the consolidated statements of financial position as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Organization's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Tyler, Simms & St. Sauveur, P.C. • 19 Morgan Drive • Lebanon, NH 03766 • Ph. 603-653-0044 • Fax 603-653-0209
www.tss-cpa.com

Emphasis of Matter

Changes in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, as of June 30, 2019, the Organization adopted Accounting Standards (ASU) 2016-14, *Presentation of Financial Statements of Not-for-Profit Entities*. The update addresses the complexity and understandability of net asset classification, information about liquidity and availability of resources, methods used to allocate costs and direction for consistency about information provided about expenses and investment return. The adoption of the standard resulted in additional footnote disclosures and changes to the classification of net assets and disclosures related to net assets. Our opinion is not modified with respect to this matter.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mid-State Health Center and Subsidiary as of June 30, 2019 and 2018, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. The consolidating information is also presented on pages 30-33 for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of the Organization's management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 19, 2019, on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control over financial reporting and compliance.

Tyler, Simms and St. Laurent, CPAs, P.C.

Lebanon, New Hampshire
November 19, 2019

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Financial Position

As of June 30, 2019 and 2018

	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 1,764,253	$ 1,453,543
Restricted cash	69,659	53,419
Patient accounts receivable, net	570,448	683,199
Estimated third-party settlements	88,708	98,348
Contracts and grants receivable	475,746	291,932
Prepaid expenses and other receivables	379,974	357,533
Total current assets	3,348,788	2,937,974
Long-term assets		
Property and equipment, net	5,832,126	6,022,468
Other assets	18,263	-
Total long-term assets	5,850,389	6,022,468
Total assets	$ 9,199,177	$ 8,960,442
Liabilities and net assets		
Current liabilities		
Accounts payable	$ 204,907	$ 122,653
Accrued expenses and other current liabilities	66,462	71,462
Accrued payroll and related expenses	374,802	350,636
Accrued earned time	308,765	354,444
Current portion of long-term debt	160,374	160,342
Current portion of capital lease obligations	591	7,460
Total current liabilities	1,115,901	1,066,997
Long-term liabilities		
Long-term debt, less current portion	4,195,066	4,348,832
Capital lease obligations, less current portion	-	791
Total long-term liabilities	4,195,066	4,349,623
Total liabilities	5,310,967	5,416,620
Commitments and contingencies (See Notes)		
Net assets without donor restrictions	3,888,210	3,543,822
Total liabilities and net assets	$ 9,199,177	$ 8,960,442

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Operations and Changes in Net Assets

For the Years Ended June 30, 2019 and 2018

	2019	2018
Changes in net assets without restrictions		
Revenue, gains and other support		
Patient service revenue (net of contractual allowances and discounts)	$ 6,721,349	$ 7,064,450
Provision for uncollectible accounts	241,053	280,637
Net patient service revenue	6,480,296	6,783,813
Contracts and grants	2,464,156	2,260,034
Contributions	13,987	13,903
Other operating revenue	1,834,609	1,308,807
Net assets released from restrictions	-	11,958
Total revenue, gains and other support	10,793,048	10,378,515
Expenses		
Salaries and wages	6,115,133	6,490,478
Employee benefits	1,378,376	1,469,123
Insurance	33,090	137,116
Professional fees	939,846	563,056
Supplies and expenses	1,472,424	1,348,770
Depreciation and amortization	306,383	297,293
Interest expense	203,408	203,415
Total expenses	10,448,660	10,509,251
Change in net assets without donor restrictions	344,388	(130,736)
Changes in net assets with donor restrictions		
Net assets released from restrictions	-	(11,958)
Change in net assets with donor restrictions	-	(11,958)
Change in net assets	344,388	(142,694)
Net assets, beginning of year	3,543,822	3,686,516
Net assets, end of year	$ 3,888,210	$ 3,543,822

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statement of Functional Expenses

For the Year Ended June 30, 2019

	Program Services						Supporting Services		
	Medical	Dental	Behavioral Health	Emergency Prep.	Montessori Center	Total Program Service	Admin and General	Fundraising	Total Expenses
Salaries and wages	$ 3,573,331	$ 396,792	$ 756,610	$ 60,951	$ 169,102	$ 4,956,786	$ 1,138,041	$ 20,307	$ 6,115,134
Employee benefits	822,119	113,606	210,897	14,304	46,585	1,207,511	166,662	4,202	1,378,375
Insurance	14,794	288	1,909	4,000	977	21,968	11,123	-	33,091
Professional fees	525,174	48,356	68,799	216,416	-	858,745	81,101	-	939,846
Supplies and expenses	1,099,113	120,679	93,303	9,755	12,712	1,335,562	136,861	-	1,472,423
Depreciation and amortization	233,417	42,663	19,599	-	1,758	297,437	8,946	-	306,383
Interest expense	164,255	17,982	12,787	-	-	195,024	8,384	-	203,408
Total expenses	$ 6,432,203	$ 740,366	$ 1,163,904	$ 305,426	$ 231,134	$ 8,873,033	$ 1,551,118	$ 24,509	$ 10,448,660

The accompanying notes to financial statements are an integral part of these statements

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statement of Functional Expenses

For the Year Ended June 30, 2018

	Program Services							Supporting Services		
	Medical	Dental	Behavioral Health	Education and Outreach	Emergency Prep.	Montessori Center	Total Program Service	Admin and General	Fundraising	Total Expenses
Salaries and wages	$ 3,989,689	$ 433,697	$ 756,546	$ 149,122	$ 60,620	$ 157,192	$ 5,546,866	$ 926,864	$ 16,748	$ 6,490,478
Employee benefits	924,393	120,726	210,233	36,570	13,617	39,948	1,345,487	120,036	3,600	1,469,123
Insurance	113,359	984	-	-	-	1,002	115,345	21,771	-	137,116
Professional fees	214,588	19,579	26,438	-	233,623	-	494,228	60,298	-	554,526
Supplies and expenses	1,032,953	98,213	90,123	12,510	7,732	8,523	1,250,054	98,716	-	1,348,770
Depreciation and amortization	213,489	51,642	22,001	-	-	1,746	288,878	8,415	-	297,293
Interest expense	165,455	16,226	13,069	-	-	-	194,750	17,195	-	211,945
Total expenses	$ 6,653,926	$ 741,067	$ 1,118,410	$ 198,202	$ 315,592	$ 208,411	$ 9,235,608	$ 1,253,295	$ 20,348	$ 10,509,251

The accompanying notes to financial statements are an integral part of these statements

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows

For the Years Ended June 30, 2019 and 2018

	2019	2018
Cash flows from operating activities		
Change in net assets	$ 344,388	$ (142,694)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	306,383	297,293
Amortization reflected as interest	2,668	2,667
Provision for uncollectible accounts	241,053	280,637
(Increase) decrease in the following assets:		
Patient accounts receivable	(128,302)	(294,199)
Estimated third-party settlements	9,640	(1,685)
Contracts and grants receivable	(183,814)	43,531
Prepaid expenses and other receivables	(22,441)	366,359
Other assets	(18,263)	-
Increase (decrease) in the following liabilities:		
Accounts payable	82,254	25,157
Accrued payroll and related expenses	24,166	21,907
Accrued earned time	(45,679)	11,178
Accrued other expenses	(5,000)	(258,431)
Net cash provided by operating activities	607,053	351,720
Cash flows from investing activities		
Purchases of property and equipment	(116,041)	(36,228)
Net cash used in investing activities	(116,041)	(36,228)
Cash flows from financing activities		
Payments on capital leases	(7,660)	(4,630)
Payments on long-term debt	(156,402)	(195,444)
Net cash used in financing activities	(164,062)	(200,074)
Net increase in cash, cash equivalents and restricted cash	326,950	115,418
Cash, cash equivalents and restricted cash, beginning of year	1,506,962	1,391,544
Cash, cash equivalents and restricted cash, end of year	$ 1,833,912	$ 1,506,962

Cash, cash equivalents and restricted cash consisted of the following as of June 30:

	2019	2018
Cash and cash equivalents	$ 1,764,253	$ 1,453,543
Restricted cash	69,659	53,419
	$ 1,833,912	$ 1,506,962

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows (continued)

For the Years Ended June 30, 2019 and 2018

Supplemental Disclosures of Cash Flow Information

	2019	2018
Cash payments for:		
Interest	$ 200,740	$ 200,748

Supplemental Disclosures of Non-Cash Transactions

During 2018, the Organization entered into a capital lease agreement to acquire equipment totaling $7,676.

The accompanying notes to financial statements are an integral part of these statements.

1. Summary of Significant Accounting Policies:

Organization

Mid-State Health Center ("MSHC") is a Federally Qualified Health Center (FQHC) which provides health care to a large number of Medicare, Medicaid and charity care patients on an outpatient basis. MSHC maintains facilities in Plymouth and Bristol, New Hampshire.

The consolidated financial statements include the accounts of Mid-State Community Development Corporation (MSCDC), collectively, "the Organization".

Effective September 23, 2010, the Organization was transferred a sole member interest in MSCDC, which owns the 19,500 square foot operating facility that was developed to house the Organization, providing medical services to the underserved community in the Plymouth, New Hampshire region.

During the year ended June 30, 2012, after having participated in a pilot program with the New Hampshire Citizens Health Initiative (NHCHI), the Organization was officially recognized as a medical home.

Basis of Statement Presentation

The consolidated financial statements are presented on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. The consolidated financial statements have been prepared consistent with the American Institute of Certified Public Accountants *Audit and Accounting Guide, Health Care Organizations* (Audit Guide). All significant intercompany transactions between MSHC and MSCDC have been eliminated in consolidation.

Effective July 1, 2018, the Organization adopted Accounting Standards Update (ASU) 2016-14 *Not-for-Profit Entities* (Topic 958). The ASU amends the current reporting model for nonprofit organizations and enhances their required disclosures. The major changes include: (a) requiring the presentation of only two classes of net assets now entitled "net assets without donor restrictions" and "net assets with donor restrictions", (b) modifying the presentation of underwater endowment funds and related disclosures, (c) requiring the use of the places in service approach to recognize the expirations of restrictions on gifts used to acquire or construct long-lived assets absent explicit donor stipulations otherwise, (d) requiring that all nonprofits present an analysis of expenses by function and nature in either the statement of activities, a separate statement or in the notes and disclose a summary of the allocation methods used to allocate costs, (e) requiring the disclosure of quantitative and qualitative information regarding liquidity and availability of resources, (f) presenting investment return net of external and direct expenses, and (g) modifying other financial statement reporting requirements and disclosures intended to increase the usefulness of nonprofit financial statements.

Implementation of ASU 2016-14 did not require reclassification or restatement of any opening balances related to the periods presented. Net assets previously reported as unrestricted are now reported as net assets without donor restrictions. Net asset previously reported as temporarily restricted net assets are now reported as net asset with donor restrictions. A footnote on liquidity has been added (Note 16).

1. Summary of Significant Accounting Policies (continued):

Classes of Net Assets

The Organization reports information regarding its consolidated financial position and activities to two classes of net assets; net assets without donor restrictions and net assets with donor restrictions.

(1) Net Assets without Donor Restrictions – represent those resources for which there are no restrictions by donors as to their use. They are reflected on the financial statements as without donor restrictions.

(2) Net Assets with Donor Restrictions – represent those resources, the uses of which have been restricted by donors to specific purposes or the passage of time and/or must retain intact, in perpetuity. The release from restrictions results from the satisfaction of the restricted purposes specified by the donor.

Estimates

The Organization uses estimates and assumptions in preparing financial statements in accordance with accounting principles generally accepted in the United States of America. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities and the reported revenues and expenses. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include demand deposits, petty cash funds and investments with a maturity of three months or less, and exclude amounts whose use is limited by Board designation or other arrangements under trust agreements or with third-party payors.

Cash in Excess of FDIC-Insured Limits

The Organization maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. Accounts are generally guaranteed by the Federal Deposit Insurance Corporation (FDIC) up to certain limits. The Organization has not experienced any losses in such accounts.

Receivables

Patient receivables are carried at their estimated collectible amounts. Patient credit is generally extended on a short-term basis; thus, patient receivables do not bear interest.

Patient receivables are periodically evaluated for collectability based on credit history and current financial condition. The Organization uses the allowance method to account for uncollectible accounts receivable.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Property and equipment donated for Organization operations are recorded at fair value at the date of receipt. Expenditures for repairs and maintenance are expensed when incurred and betterments are capitalized.

1. **Summary of Significant Accounting Policies (continued):**

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under capital leases is amortized on the straight-line method over the life of the capital lease. Such amortization is included in depreciation and amortization in the financial statements.

Estimated useful lives are as follows:

	YEARS
Buildings	5 - 40
Leasehold improvements	5
Equipment	3 - 7
Furniture and fixtures	5 - 15
Capital leases	3 – 15

The Organization reviews the carrying value of property and equipment for impairment whenever events and circumstances indicate that the carrying value of an asset may not be recoverable from the estimated future cash flows expected to result from its use and eventual disposition. In cases where undiscounted expected future cash flows are less than carrying value, an impairment loss is recognized equal to an amount by which the carrying value exceeds the fair value of assets. The factors considered by management in performing this assessment include current operating results, trends and prospects, as well as the effects of obsolescence, demand, competition and other economic factors.

Contractual Arrangements with Third-Party Payors

The Medicare and Medicaid programs pay the Organization for services at predetermined rates by treatment. The Organization is reimbursed for Medicare cost reimbursable items at a tentative rate with final settlement determined after the submission of annual cost reports and audits thereof by the Medicare fiscal intermediary. Changes in Medicare and Medicaid programs or reduction of funding levels for programs could have an adverse effect on future amounts recognized as net patient service revenue.

The laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

The Organization also enters into preferred provider agreements with certain commercial insurance carriers. Payment arrangements to the Organization under these agreements include discounted charges and fee schedule payments.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors.

1. Summary of Significant Accounting Policies (continued):

Grant Revenue

The Organization recognizes support funded by grants determined to be exchange transactions as the Organization performs the contracted services or incurs outlays eligible for reimbursement under the grant agreements. Grant activities and outlays are subject to audit and acceptance by the granting agency and, as a result of such audit, adjustments could be required.

Contributions

Contributions are recognized at the earlier of when cash is received or at the time a pledge becomes unconditional in nature. Contributions are recorded in the net asset classes described earlier depending on the existence and/or nature of any donor restriction. When a restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statement of activities as net assets releases from restriction. Restricted contributions that are satisfied in the same reporting period are classified as net assets without donor restriction.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy with minimal charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Income Taxes

MSHC and MSCDC are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and are exempt from Federal income taxes on related income pursuant to Section 501(a) of the Code.

The Organization accounts for its uncertain tax positions in accordance with the accounting methods under ASC Subtopic 740-10. The UTP rules prescribe a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken in an organization's tax return. The Organization believes that it has appropriate support for the tax positions taken and, as such, does not have any uncertain tax positions that might result in a material impact on the Organization's statements of financial position, activities and changes in net assets and cash flows. The Organization's management believes it is no longer subject to examinations for the years prior to 2015.

Advertising

Advertising costs are charged to operations when incurred. Total advertising expense for the years ended June 30, 2019 and 2018 was $22,105 and $23,034, respectively.

Functional Allocation of Expenses

Expenses that can be identified with specific program or supporting services are charged directly to the related program or supporting service. Expenses that are associated with more than one program or supporting service are allocated based on an evaluation by management utilizing measurements for time and effort, square footage and/or encounter based statistics.

1. Summary of Significant Accounting Policies (continued):

Excess (Deficit) of Revenues over Expenses

The consolidated statements of operations include excess (deficit) of revenues over expenses. Changes in net assets without restrictions which are excluded from excess (deficit) of revenues over expenses, consistent with industry practice, include contributions and grants of long-lived assets.

Fair Value of Financial Instruments

The carrying amount of cash, patient accounts receivable, accounts and notes payable and accrued expenses approximates fair value.

Reclassifications

Certain reclassifications have been made to the prior year's financial statements to conform to the current year presentation. These reclassifications have no effect on the previously reported change in net assets.

Liquidity

Assets are presented in the accompanying consolidated statements of financial position according to their nearness of conversion to cash and liabilities according to the nearness of their maturity and resulting use of cash.

New Pronouncements

The FASB issued ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made.* The ASU which becomes effective for the Organization's consolidated financial statements as of and for the year ending June 30, 2020, provides guidance on whether a receipt from a third-party resource provider should be accounted for as a contribution (nonreciprocal transaction) within the scope of Topic 958, *Not-for-Profit Entities*, or as an exchange (reciprocal) transaction.

The FASB issued ASU No. 2016-02, *Leases.* The ASU, which becomes effective for the Organization's consolidated financial statements as of and for the year ending June 30, 2021, requires the full obligation of long-term leases to be recorded as a liability with a corresponding right of use asset on the statement of financial position.

The Organization is evaluating the impact of these standards on its future financial statements.

2. Charity Care:

The Organization maintains records to identify and monitor the level of charity care they provide. These records include the amount of charges foregone for services and supplies furnished under their charity care policies. The total cost estimate is based on an overall cost-to-charge ratio applied against gross charity care charges. The net cost of charity care provided was approximately $280,000 and $337,000 for the years ended June 30, 2019 and 2018, respectively.

2. Charity Care (continued):

In 2019 and 2018, 564 and 533 patients received charity care out of a total of 11,539 and 10,771 patients, respectively. The Organization provides health care services to residents of Plymouth, New Hampshire as well as Bristol, New Hampshire and their surrounding areas, without regard to the individual's ability to pay for their services.

Determination of eligibility for charity care is granted on a sliding fee basis:

For dental services, patients with family income less than 100% of the Community Services Administration Income Poverty Guidelines shall only be responsible for a nominal fee assessed by the Organization and not the balance of their account for services received. Those with family income at least equal to 101%, but not exceeding 125% of the Federal Poverty Guidelines, receive a 65% discount. Those with family income at least equal to 126%, but not exceeding 150% of the guidelines, receive a 55% discount. Those with family income at least equal to 151%, but not exceeding 200% of the guidelines, receive a 45% discount.

For all other services, patients with family income less than 100% of the Community Services Administration Income Poverty Guidelines shall only be responsible for a nominal fee assessed by the Organization and not the balance of their account for services received. Those with family income at least equal to 101%, but not exceeding 138% of the Federal Poverty Guidelines, shall be responsible for a $20 fee for each encounter. Those with family income at least equal to 139%, but not exceeding 160% of the guidelines, will be responsible for a $30 fee for each encounter. Those with family income at least equal to 161%, but not exceeding 180% of the guidelines, will be responsible for a $40 fee for each encounter. Those with family income at least equal to 181%, but not exceeding 200% of the guidelines, will be responsible for a $50 fee for each encounter.

3. Patient Service Revenue and Patient Accounts Receivable:

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized was as follows for the years ended June 30:

	2019			
	Gross Charges	Contractual Adjustments	Sliding Fee Adjustments	Patient Service Revenue
Medicare	$ 3,168,938	$ 736,684	$ -	$ 2,432,254
Medicaid	1,780,916	576,871	-	1,204,045
Blue Cross	1,943,516	681,502	-	1,262,014
Other third-party payors	2,212,431	754,360	-	1,458,071
Self-pay	621,569	-	256,604	364,965
Total	$ 9,727,370	$ 2,749,417	$ 256,604	$ 6,721,349

3. Patient Service Revenue and Patient Accounts Receivable (continued):

	2018			
	Gross	Contractual	Sliding Fee	Patient Service
Medicare	$ 3,056,284	$ 760,522	$ -	$ 2,295,762
Medicaid	1,629,184	358,716	-	1,270,468
Blue Cross	2,012,056	587,538	-	1,424,518
Other third-party payors	2,491,465	781,926	-	1,709,539
Self-pay	733,202	-	369,039	364,163
Total	$ 9,922,191	$ 2,488,702	$ 369,039	$ 7,064,450

Patient accounts receivable is reported net of estimated contractual allowances and allowance for doubtful accounts, as follows, as of June 30:

	2019	2018
Patient accounts receivable	$ 1,247,726	$ 1,266,792
Less: Estimated contractual allowances and discounts	360,278	348,593
Less: Estimated allowance for uncollectible accounts	317,000	235,000
Patient accounts receivable, net	$ 570,448	$ 683,199

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with service provided to patients who have third-party coverage, the Organization analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients, including both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for only part of the bill, the Organization records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

4. Estimated Third-Party Settlements:

Provision has been made for estimated adjustments that may result from final settlement of reimbursable amounts as may be required upon completion and audit of related cost finding reports under terms of contracts with the Center for Medicare and Medicaid Services and the New Hampshire Division of Welfare (Medicaid). Differences between estimated adjustments and amounts determined to be recoverable or payable are accounted for as income or expense in the year that such amounts become known.

5. Grants and State Contracts:

The Organization receives various reimbursement grants from the federal government, State of New Hampshire and other public and private agencies. The following is a summary of the grant activity for the years ended June 30:

	Grant and State Contract Revenue		Outstanding Receivable	
	2019	2018	2019	2018
HRSA 330 Grant - 2018-2022	$ 1,585,879	$ 1,500,224	$ 284,968	$ 141,281
Bi-State PCA Grant	154,332	8,238	105,528	-
NH Primary Care Contracts	153,293	150,146	25,550	38,324
Emergency Preparedness Grants	322,620	338,502	39,837	93,644
HRSA-IGNITE Grants	80,641	163,970	-	-
Other Grant and Contract Awards	167,391	98,954	19,863	18,683
	$ 2,464,156	$ 2,260,034	$ 475,746	$ 291,932

6. Property and Equipment:

Property and equipment consisted of the following as of June 30:

	2019	2018
Land	$ 525,773	$ 525,773
Buildings	6,346,118	6,346,118
Leasehold improvements	170,174	170,174
Furniture, fixtures and equipment	1,400,452	1,284,411
	8,442,517	8,326,476
Less: Accumulated depreciation	2,610,391	2,304,008
	$ 5,832,126	$ 6,022,468

Depreciation and amortization expense, including amortization expense on capital lease obligations, for the years ended June 30, 2019 and 2018 amounted to $306,383 and $297,293, respectively.

7. Line of Credit:

The Organization had an available line of credit with a maximum borrowing amount of $150,000 and $100,000 as of June 30, 2019 and 2018, respectively. The line carries an interest rate equal to 7% (prime plus 2%). The line is secured by all business assets. The line was not drawn upon as of June 30, 2019 and 2018.

8. Long-Term Debt:

Long-term debt consisted of the following as of June 30:

	2019	2018
Woodsville Guarantee Savings Bank note payable, maturing August 2033, principal and interest payable in 240 monthly installments of $18,194 through August 2033. Interest is charged at a rate of 5.25%.	$ 2,178,682	$ 2,279,730
Woodsville Guarantee Savings Bank note payable, maturing August 2018, principal and interest payable in 60 monthly installments of $3,757. Interest is charged at a rate of 4%.	-	7,477
United States of America Department of Agriculture note payable, maturing April 2045, principal and interest payable in 360 monthly payments of $10,904. Interest is charged at a rate of 3.5% (see Note 9a).	2,216,849	2,264,725
Total long-term debt	4,395,531	4,551,932
Less: unamortized deferred financing costs	40,091	42,758
Total long-term debt, net of unamortized deferred financing costs	4,355,440	4,509,174
Less: current portion	160,374	160,342
Long-term debt, less current portion	$ 4,195,066	$ 4,348,832

9a In September 2013, the Organization refinanced its then outstanding Woodsville Guarantee Savings Bank interim note payable with a construction loan. The new loan had an advancement amount of up to $2,700,000 and called for interest only payments at a rate of 5% beginning October 2013, for 23 consecutive months, and 1 balloon payment of principal and accrued unpaid interest due September 2015. In April 2015, the Organization entered into a long-term debt arrangement with the United States of America Department of Agriculture ("USDA") totaling $2,423,000. The proceeds from the loan were used to refinance the construction loan balance and unpaid accrued interest and to satisfy outstanding invoices related to the construction of the Bristol property. The loan is secured by the Organization's property located in Bristol, New Hampshire. The loan agreement requires the Organization to establish a reserve account which is to be funded in monthly installments of $1,090 until the accumulated sum of reserve funding reaches $130,848, after which no further funding is required except to replace withdrawals. As of June 30, 2019, the reserve account totaled $69,659, reflected on the consolidated statement of financial position as restricted cash.

Future maturities of long-term debt are as follows as of June 30, 2019:

2020	$ 160,374
2021	168,229
2022	176,256
2023	184,679
2024	193,328
Thereafter	3,512,665
	$ 4,395,531

9. Capital Lease Obligations:

As of June 30, 2019, the Organization had an outstanding capital lease obligation for a certain piece of equipment. The term of the lease agreement is for a period of 48 months expiring in 2019. Accordingly, the Organization has recorded the transaction as a capital lease obligation. For the years ended June 30, 2019 and 2018, amortization expense on the asset acquired through capital lease totaled $2,000 and was included within depreciation and amortization expense on the consolidated statement of functional expenses. The cost basis of the equipment under capital lease as of June 30, 2019 was $8,000. Accumulated amortization was $7,667 and $5,667 as of June 30, 2019 and 2018, respectively.

The following is a schedule, by year, of future minimum lease payments under the capital leases as of June 30:

2020	$ 600
Total minimum lease payments	600
LESS: Amount representing interest	9
Present value of minimum lease payments	591
LESS: Current portion	591
Long-term capital lease obligation	$ -

10. Malpractice Insurance Coverage:

The U.S. Department of Health and Human Services deemed the Organization covered under the Federal Tort Claims Act (FTCA) for damage for personal injury, including death, resulting from the performance of medical, surgical, dental and related functions. FTCA coverage is comparable to an occurrence policy without a monetary cap. Prior to being deemed for coverage under the FTCA, the Organization purchased medical malpractice insurance under a claims-made policy on a fixed premium basis. The Organization purchases primary and excess liability malpractice insurance under occurrence policies for certain services and other portions of the Organization not covered under FTCA.

Claim liabilities are determined without consideration of insurance recoveries. Expected recoveries are presented separately. Management analyzes the need for an accrual of estimated losses of medical malpractice claims, including an estimate of the ultimate costs of both reported claims and claims incurred but not reported. In such cases, the expected recovery from the Organization's insurance provider is recorded within prepaid expenses and other receivables. As of June 30, 2019 and 2018, subsequent to management's assessment of potential reported and not yet reported claims, management determined that its exposure for potential unreported claims was immaterial and consequently did not provide for an accrual. It is possible that an event has occurred which will be the basis of a future material claim.

11. Commitments and Contingencies:

Real Estate Taxes – The Organization and the Town of Plymouth, NH agreed to a payment in lieu of real estate taxes for a period of 10 years. The agreement identified real estate taxes previously paid by the Organization to the Town that the Organization was not required to pay as a result of its tax-exempt status. The sum of the overpayments will be applied evenly on an installment basis over the 10-year period, totaling $50,000. The Organization remains subject to its requirement to timely file its application for tax exemption with the Town on an annual basis.

11. Commitments and Contingencies (continued):

340B Revenue – The Organization participates in the 340B Drug Discount Program (the 340B Program) which enables qualifying health care providers to purchase drugs from pharmaceutical suppliers at a substantial discount as a Covered Entity. The 340B Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs. The Organization is required to undergo a self-audit process to determine compliance with 340B Program guidelines. The 340B statutes also explicitly authorize HRSA to audit Covered Entities to ensure they are compliant with the 340B Program. All Covered Entities are also required to recertify compliance with the 340B Program on an annual basis, including an attestation to full compliance with the 340B Program. The Organization earns revenue under the 340B Program by purchasing pharmaceuticals at a reduced cost to fill prescriptions to qualified patients. The Organization contracts with certain third-party pharmacies that dispense the pharmaceuticals to its patients. 340B revenue is included in other operating revenue within the consolidated statements of operations and totaled $1,476,030 and $1,062,379 for the years ended June 30, 2019 and 2018, respectively. The cost of pharmaceuticals, dispensing fees to the pharmacies, consulting fees and other costs associated with the 340B Program are included in operating expenses in the consolidated statements of operations and totaled $512,776 and $353,521 for the years ended June 30, 2019 and 2018, respectively.

12. Concentration of Credit Risk:

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors was as follows at June 30:

	2019	2018
Medicare	11.7%	15.4%
Medicaid	22.2%	20.9%
Blue Cross	15.7%	18.6%
Patients	22.7%	14.9%
Other third-party payors	27.7%	30.2%
	100.0%	100.0%

13. Other Operating Revenue:

The following summarizes components of other operating revenue for the years ended June 30:

	2019	2018
Other operating revenue:		
Pharmacy income - 340B	$ 1,476,030	$ 1,062,379
Anthem shared savings	83,807	28,835
Montessori Center	155,676	164,008
Other operating revenue	119,096	53,585
	$ 1,834,609	$ 1,308,807

14. Retirement Program:

During 2007, the Organization adopted a tax-sheltered annuity plan under 403(b) of the Code for eligible employees. Eligible employees are specified as those who normally work more than 20 hours per week and are not classified as independent contractors. The Organization provides for matching of employee contributions, 50% of the first 6% contributed. Contributions to the plan for the years ended June 30, 2019 and 2018 were $144,309 and $154,961, respectively.

15. Health Insurance:

Prior to the fiscal year ended June 30, 2019, the Organization offered health insurance benefits to all employees under available Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) plans.

During the year ended June 30, 2019, the Organization began participation in a captive health insurance plan (Captive Plan). The Organization is subject to a stop-loss limit of $50,000 per participant in the Plan before additional coverage through the captive arrangement will commence coverage of claims. Claims submitted to the Captive Plan for reimbursement after the end of the fiscal year with service dates on or prior to June 30 are required to be recognized as a loss in the period in which they occurred. As such, the Organization has provided for a liability for unpaid claims with service dates as of or before June 30 which had not yet been reported totaling $28,500, included under the caption "accrued expenses and other current liabilities".

Deductible requirements under the Captive Plan range from $2,000 to $4,000, depending on the coverage selected, before the Organization, under its' health reimbursement arrangement, is obligated to pay up to $500 per participant.

The Organization provides for an accrual based on the aggregate amount of the liability for reported claims and an estimated liability for claims incurred but not yet reported. At June 30, 2019 and 2018, "accrued expenses and other current liabilities" include an accrued liability related to these plans of $20,000 and $819, respectively.

16. Liquidity:

Financial assets available for general expenditures within one year of the balance sheet date consist of the following as of June 30:

	2019	2018
Cash and cash equivalents	$ 1,764,253	$ 1,453,543
Patient accounts receivable, net	570,448	683,199
Estimated third-party settlements	88,708	98,348
Contracts and grant receivable	475,746	291,932
Other receivables	263,318	206,716
	$ 3,162,473	$ 2,733,738

16. Liquidity (continued):

As part of its liquidity management strategy, the Organization structures its financial assets to be available as its general expenditures, liabilities and other obligations as they come due. The Organization has certain restricted cash balances totaling $69,659 and $53,419 as of June 30, 2019 and 2018, respectively, representing funds required to be set aside as a building maintenance reserve for the Organization's Bristol, New Hampshire location. These balances have not been included in the Organization financial assets available for general expenditure within one year.

17. Subsequent Events:

The Organization has reviewed events occurring after June 30, 2019 through November 19, 2019, the date the board of trustees accepted the final draft of the consolidated financial statements and made them available to be issued. The Organization has not identified other events requiring disclosure that have occurred between the period of June 30, 2019 and the report date, November 19, 2019. The Organization has not reviewed events occurring after the report date for their potential impact on the information contained in these consolidated financial statements.

MID-STATE HEALTH CENTER
Schedule of Expenditures of Federal Awards
For the Year Ended June 30, 2019

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number	Pass-through Entity or Award Identifying Number	Federal Expenditures	Passed through to Subrecipients
U.S. Department of Health and Human Services:				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care)	93.224		$ 1,585,879	$ -
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement Program	93.912		80,641	-
Passed through Bi-State Primary Care Association, Inc.:				
Grants to States to Support Oral Health Workforce Activities	93.236	T12HP30316	154,322	-
Total passed through Bi-State Primary Care Association, Inc.			154,322	-
Passed through N.H. Department of Health and Human Services:				
Block Grants for Prevention and Treatment of Substance Abuse	93.959	FAIN TI010035	110,382	-
Immunization Cooperative Agreements	93.268	FAIN H23IP000757	10,300	-
Preventive Health and Health Services Block Grant Funded Solely with Prevention and Public Health Funds (PPHF)	93.758	FAIN B01OT009037	5,767	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074 Comprised of 93.889 & 93.069	FAIN U90TP000535	49,492	-
Maternal and Child Health Services Block Grant to the States	93.994	Unknown	39,854	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	FAIN SP020796	110,000	-
Total passed through N.H. Department of Health and Human Services			325,795	-
Total U.S. Department of Health and Human Services			2,146,637	-
TOTAL EXPENDITURES OF FEDERAL AWARDS			$ 2,146,637	$ -

The accompanying notes to financial statements are an integral part of this schedule.

MID-STATE HEALTH CENTER

Notes to Schedule of Expenditures of Federal Awards

For the Year Ended June 30, 2019

1. Basis of Presentation:

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) includes the federal award activity of MSHC under programs of the federal government for the year ended June 30, 2019. The information in the schedule is presented in accordance with the requirements of Title 2 US. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Since the schedule presents only a selected portion of the operations of MSHC, it is not intended to and does not present the statement of financial position, statement of operations and changes in net assets or cash flows of MSHC.

2. Significant Accounting Policies:

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. The Schedule includes Catalog of Federal Domestic Assistance (CFDA) and pass-through award numbers when available.

3. Indirect Cost Rate:

MSHC elected to use the 10% de minimis indirect cost rate.

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Report I

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Trustees of
Mid-State Health Center:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Mid-State Health Center ("MSHC") (a nonprofit organization), which comprise the statement of financial position as of June 30, 2019, and the related statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 19, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered MSHC's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of MHSC's internal control. Accordingly, we do not express an opinion on the effectiveness of MSHC's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* (continued)

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether MSHC's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Tyler, Simms and St. Saveur, CPAs, P.C.

Lebanon, New Hampshire
November 19, 2019

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Report 2

Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance

To the Board of Trustees of
Mid-State Health Center:

Report on Compliance for Each Major Federal Program

We have audited Mid-State Health Center's ("MSHC") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of MSHC's major federal programs for the year ended June 30, 2019. MHSC's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of MSHC's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about MSHC's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of MSHC's compliance.

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Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance (continued)

Opinion on Each Major Federal Program

In our opinion, MSHC complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2019.

Report on Internal Control Over Compliance

Management of MSHC is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered MSHC's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of MSHC's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Tyler, Simms and St. Laurent, CPAs, P.C.

Lebanon, New Hampshire
November 19, 2019

MID-STATE HEALTH CENTER
Schedule of Findings and Questioned Costs
As of and For the Year Ended June 30, 2019

SECTION I - SUMMARY OF AUDITORS' RESULTS

Financial Statements

Type of auditors' report issued	*Unmodified*
Internal control over financial reporting:	
Material weakness identified	____ Yes __X__ No
Significant deficiencies identified that are not considered to be material weaknesses	____ Yes __X__ None reported
Non-compliance material to financial statements noted	____ Yes __X__ No

Federal Awards

Internal control over major programs:	
Material weakness identified	____ Yes __X__ No
Significant deficiencies identified that are not considered to be material weaknesses	____ Yes __X__ None reported
Type of auditors' report issued on compliance for major programs	*Unmodified*
Any audit findings disclosed that are required to be reported in accordance with Section 200.516(a) of the Uniform Guidance	____ Yes __X__ No

Identification of major programs:

Federal CFDA Number	Name of Federal/Local Program
93.224	Health Center Program

Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	__X__ Yes ____ No

SECTION II - FINANCIAL STATEMENT FINDINGS

There were no findings related to the financial statements which are required to be reported in accordance with generally accepted Government Auditing Standards (GAGAS).

SECTION III - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

There were no findings or questioned costs for Federal awards (as defined in Section 200.516(a) of the Uniform Guidance) that are required to be reported.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Financial Position – Schedule 1

As of June 30, 2019

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Assets				
Current assets				
Cash and cash equivalents	$ 1,273,179	$ 491,074	$ -	$ 1,764,253
Restricted cash	69,659	-	-	69,659
Patient accounts receivable, net	570,448	-	-	570,448
Estimated third-party settlements	88,708	-	-	88,708
Contracts and grants receivable	475,746	-	-	475,746
Prepaid expenses and other receivables	417,584	-	(37,610)	379,974
Total current assets	2,895,324	491,074	(37,610)	3,348,788
Long-term assets				
Property and equipment, net	2,547,312	3,284,814	-	5,832,126
Other assets	139,882	-	(121,619)	18,263
Total long-term assets	2,687,194	3,284,814	(121,619)	5,850,389
Total assets	$ 5,582,518	$ 3,775,888	$ (159,229)	$ 9,199,177
Liabilities and net assets				
Current liabilities				
Accounts payable	$ 204,907	$ 37,610	$ (37,610)	$ 204,907
Accrued expenses and other current liabilities	51,001	15,461	-	66,462
Accrued payroll and related expenses	374,802	-	-	374,802
Accrued earned time	308,765	-	-	308,765
Current portion of long-term debt	53,891	106,483	-	160,374
Current portion of capital lease obligations	591	-	-	591
Total current liabilities	993,957	159,554	(37,610)	1,115,901
Long-term liabilities				
Lease deposits	-	121,619	(121,619)	-
Long-term debt, less current portion	2,157,382	2,037,684	-	4,195,066
Capital lease obligations, less current portion	-	-	-	-
Total long-term liabilities	2,157,382	2,159,303	(121,619)	4,195,066
Total liabilities	3,151,339	2,318,857	(159,229)	5,310,967
Net assets without donor restrictions	2,431,179	1,457,031	-	3,888,210
Total liabilities and net assets	$ 5,582,518	$ 3,775,888	$ (159,229)	$ 9,199,177

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Operations and Changes in Net Assets – Schedule 2

For the Year Ended June 30, 2019

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Changes in net assets without donor restrictions				
Revenue, gains and other support				
Patient service revenue (net of contractual allowances and discounts)	$ 6,721,349	$ -	$ -	$ 6,721,349
Provision for uncollectible accounts	241,053	-	-	241,053
Net patient service revenue	6,480,296	-	-	6,480,296
Contracts and grants	2,464,156	-	-	2,464,156
Contributions	13,987	-	-	13,987
Other operating revenue	1,913,520	310,149	(389,060)	1,834,609
Net assets released from restrictions	-	-	-	-
Total revenue, gains and other support	10,871,959	310,149	(389,060)	10,793,048
Expenses				
Salaries and wages	6,115,133	-	-	6,115,133
Employee benefits	1,378,376	-	-	1,378,376
Insurance	33,090	-	-	33,090
Professional fees	901,493	119,202	(80,849)	939,846
Supplies and expenses	1,779,867	768	(308,211)	1,472,424
Depreciation and amortization	187,743	118,640	-	306,383
Interest expense	83,642	119,766	-	203,408
Total expenses	10,479,344	358,376	(389,060)	10,448,660
Change in net assets without donor restrictions	392,615	(48,227)	-	344,388
Net assets, beginning of year	2,038,564	1,505,258	-	3,543,822
Net assets, end of year	$ 2,431,179	$ 1,457,031	$ -	$ 3,888,210

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Financial Position – Schedule 3

As of June 30, 2018

	MSHC	MSCDC	ELIMINATION	TOTAL
Assets				
Current assets				
Cash and cash equivalents	$ 946,166	$ 507,377	$ -	$ 1,453,543
Restricted cash	53,419	-	-	53,419
Patient accounts receivable, net	683,199	-	-	683,199
Estimated third-party settlements	98,348	-	-	98,348
Contracts and grants receivable	291,932	-	-	291,932
Prepaid expenses and other receivables	375,333	-	(17,800)	357,533
Total current assets	2,448,397	507,377	(17,800)	2,937,974
Long-term assets				
Property and equipment, net	2,619,014	3,403,454	-	6,022,468
Deposits and other assets	121,376	-	(121,376)	-
Total long-term assets	2,740,390	3,403,454	(121,376)	6,022,468
Total assets	$ 5,188,787	$ 3,910,831	$ (139,176)	$ 8,960,442
Liabilities and net assets				
Current liabilities				
Accounts payable	$ 122,653	$ 17,800	$ (17,800)	$ 122,653
Accrued expenses and other current liabilities	55,306	16,156	-	71,462
Accrued payroll and related expenses	350,636	-	-	350,636
Accrued earned time	354,444	-	-	354,444
Current portion of long-term debt	51,817	108,525	-	160,342
Current portion of capital lease obligations	7,460	-	-	7,460
Total current liabilities	942,316	142,481	(17,800)	1,066,997
Long-term liabilities				
Lease deposits	-	121,376	(121,376)	-
Long-term debt, less current portion	2,207,116	2,141,716	-	4,348,832
Capital lease obligations, less current portion	791	-	-	791
Total long-term liabilities	2,207,907	2,263,092	(121,376)	4,349,623
Total liabilities	3,150,223	2,405,573	(139,176)	5,416,620
Net assets without donor restrictions	2,038,564	1,505,258	-	3,543,822
Total liabilities and net assets	$ 5,188,787	$ 3,910,831	$ (139,176)	$ 8,960,442

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Operations and Changes in Net Assets – Schedule 2

For the Year Ended June 30, 2018

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Changes in net assets without donor restrictions				
Revenue, gains and other support				
Patient service revenue (net of contractual allowances and discounts)	$ 7,064,450	$ -	$ -	$ 7,064,450
Provision for uncollectible accounts	280,637	-	-	280,637
Net patient service revenue	6,783,813	-	-	6,783,813
Contracts and grants	2,260,034	-	-	2,260,034
Contributions	13,903	-	-	13,903
Other operating revenue	1,308,265	308,753	(308,211)	1,308,807
Net assets released from restrictions	11,958	-	-	11,958
Total revenue, gains and other support	10,377,973	308,753	(308,211)	10,378,515
Expenses				
Salaries and wages	6,490,478	-	-	6,490,478
Employee benefits	1,469,123	-	-	1,469,123
Insurance	137,116	-	-	137,116
Professional fees	554,526	8,530	-	563,056
Supplies and expenses	1,645,044	11,937	(308,211)	1,348,770
Depreciation and amortization	178,653	118,640	-	297,293
Interest expense	77,275	126,140	-	203,415
Total expenses	10,552,215	265,247	(308,211)	10,509,251
Change in net assets without donor restrictions	(174,242)	43,506	-	(130,736)
Changes in net assets with donor restrictions				
Net assets released from restrictions	(11,958)	-	-	(11,958)
Change in net assets with donor restrictions	(11,958)	-	-	(11,958)
Change in net assets	(186,200)	43,506	-	(142,694)
Net assets, beginning of year	2,224,764	1,461,752	-	3,686,516
Net assets, end of year	$ 2,038,564	$ 1,505,258	$ -	$ 3,543,822

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Financial Statements

As of and for the Years Ended
June 30, 2021 and 2020

Supplemental Schedule of Expenditures of Federal Awards

For the Year Ended June 30, 2021

and

Independent Auditors' Report

MID-STATE
HEALTH CENTER

MID-STATE HEALTH CENTER AND SUBSIDAIRY

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As of and for the Years Ended June 30, 2021 and 2020

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Independent Auditors' Report

To the Board of Trustees of
Mid-State Health Center and Subsidiary:

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Mid-State Health Center and Subsidiary, which comprise the consolidated statements of financial position as of June 30, 2021 and 2020, and the related consolidated statements of operations and changes in net assets, functional expenses and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Organization's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mid-State Health Center and Subsidiary as of June 30, 2021 and 2020, and the results of their operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

Change in Accounting Principle

As discussed in Note 1 to the consolidated financial statements, in 2021 the Organization adopted Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* using the full retrospective approach. Our opinion is not modified with respect to this matter.

Other Matters

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the financial statements. The consolidating information is also presented on pages 32-35 for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of the Organization's management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 18, 2021, on our consideration of the Organization's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control over financial reporting and compliance.

Tyler, Simms and St. Laurent, CPAs, P.C.

Lebanon, New Hampshire
November 18, 2021

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Financial Position

As of June 30, 2021 and 2020

	2021	2020
Assets		
Current assets		
Cash and cash equivalents	$ 3,392,262	$ 3,823,909
Restricted cash	91,843	78,578
Patient services receivable, net	1,058,656	646,271
Government grants receivable	483,166	467,760
Contract and other receivables	483,643	488,718
Promises to give	40,000	-
Prepaid expenses and other current assets	108,308	73,297
Total current assets	5,657,878	5,578,533
Long-term assets		
Property and equipment, net	7,844,779	5,978,859
Other assets	42,424	42,182
Total long-term assets	7,887,203	6,021,041
Total assets	$ 13,545,081	$ 11,599,574
Liabilities and net assets		
Current liabilities		
Accounts payable	$ 303,778	$ 329,626
Accrued expenses and other current liabilities	1,218,636	1,029,869
Refundable advance	135,525	578,105
Short-term note payable	-	484,000
Current portion of long-term debt	143,471	176,509
Total current liabilities	1,801,410	2,598,109
Long-term liabilities		
Long-term debt, less current portion	5,341,325	5,376,892
Total long-term liabilities	5,341,325	5,376,892
Total liabilities	7,142,735	7,975,001
Commitments and contingencies (See Notes)		
Net assets without donor restrictions	6,362,346	3,624,573
Net assets with donor restrictions	40,000	-
Total net assets	6,402,346	3,624,573
Total liabilities and net assets	$ 13,545,081	$ 11,599,574

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Operations and Changes in Net Assets

For the Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenues and other support without donor restrictions		
Net patient services revenue	$ 8,134,867	$ 7,045,574
Contract revenue	2,234,130	1,792,439
Other operating revenue	509,633	612,459
Government grants	5,115,185	2,485,691
Contributions	80,042	35,973
Total operating revenues and other support without donor restrictions	16,073,857	11,972,136
Operating expenses		
Salaries and wages	8,161,829	7,270,657
Employee benefits	2,339,699	1,568,194
Insurance	59,727	54,511
Professional fees	1,402,436	1,153,554
Supplies and expenses	2,092,022	1,694,199
Depreciation and amortization	310,027	301,808
Interest expense	201,996	192,850
Total operating expenses	14,567,736	12,235,773
Operating income (loss)	1,506,121	(263,637)
Nonoperating income (loss)		
Paycheck Protection Program debt forgiveness	1,118,000	-
Government grants for capital acquisitions	148,325	-
Loss on debt refinancing	(34,673)	-
Total nonoperating income (loss)	1,231,652	-
Increase (decrease) in net assets without donor restrictions	2,737,773	(263,637)
Changes in net assets with donor restrictions		
Contributions	40,000	-
Increase (decrease) in net assets	2,777,773	(263,637)
Net assets, beginning of year	3,624,573	3,888,210
Net assets, end of year	$ 6,402,346	$ 3,624,573

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statement of Functional Expenses

For the Year Ended June 30, 2021

	Program Services						Supporting Services		
	Medical	Dental	Behavioral Health	Emergency Prep.	Montessori Center	Total Program Service	Admin and General	Fundraising	Total Expenses
Salaries and wages	$ 5,065,607	$ 680,610	$ 932,439	$ 83,998	$ 178,651	$ 6,941,305	$ 1,174,687	$ 45,837	$ 8,161,829
Employee benefits	1,478,162	216,610	313,062	22,170	70,424	2,100,428	231,006	8,265	2,339,699
Insurance	37,489	453	3,700	1,918	1,442	45,002	14,725	-	59,727
Professional fees	827,124	7,857	152,928	279,857	-	1,267,766	134,670	-	1,402,436
Supplies and expenses	1,453,154	189,297	112,676	67,346	40,424	1,862,897	229,125	-	2,092,022
Depreciation and amortization	215,468	30,020	47,964	4,615	1,758	299,825	10,202	-	310,027
Interest expense	148,810	12,016	32,664	-	-	193,490	8,506	-	201,996
Total expenses	$ 9,225,814	$ 1,136,863	$ 1,595,433	$ 459,904	$ 292,699	$ 12,710,713	$ 1,802,921	$ 54,102	$ 14,567,736

The accompanying notes to financial statements are an integral part of these statements

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statement of Functional Expenses

For the Year Ended June 30, 2020

	Program Services						Supporting Services		
	Medical	Dental	Behavioral Health	Emergency Prep.	Montessori Center	Total Program Service	Admin and General	Fundraising	Total Expenses
Salaries and wages	$ 4,190,371	$ 694,205	$ 815,564	$ 94,716	$ 185,738	$ 5,980,594	$ 1,268,455	$ 21,608	$ 7,270,657
Employee benefits	961,559	158,116	235,976	16,056	48,148	1,419,855	143,928	4,412	1,568,194
Insurance	30,240	876	3,691	-	1,297	36,104	18,407	-	54,511
Professional fees	749,364	9,594	111,113	199,114	-	1,069,185	84,369	-	1,153,554
Supplies and expenses	1,143,430	126,020	143,073	22,981	53,693	1,489,197	205,002	-	1,694,199
Depreciation and amortization	205,100	41,749	43,997	-	1,466	292,312	9,496	-	301,808
Interest expense	142,764	18,878	23,316	-	-	184,958	7,892	-	192,850
Total expenses	$ 7,422,828	$ 1,049,438	$ 1,376,730	$ 332,867	$ 290,342	$ 10,472,205	$ 1,737,549	$ 26,020	$ 12,235,773

The accompanying notes to financial statements are an integral part of these statements

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows

For the Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Increase (decrease) in net assets	$ 2,777,773	$ (263,637)
Adjustments to reconcile increase (decrease) in net assets to net cash provided by operating activities		
Depreciation and amortization	310,027	301,808
Paycheck Protection Program debt forgiveness	(1,118,000)	-
N.H. Healthcare Provider Relief Program loan conversion	(484,000)	-
Government grants for capital acquisitions	(148,325)	-
Amortization reflected as interest	3,801	(2,668)
Loss on debt refinancing	34,673	-
(Increase) decrease in the following assets:		
Patient services receivable	(412,385)	(75,823)
Government grants receivable	(15,406)	(22,219)
Promises to give	(40,000)	-
Other receivables	5,075	(109,567)
Prepaid expenses and other current assets	(35,011)	46,439
Other assets	(242)	(23,919)
Increase (decrease) in the following liabilities:		
Accounts payable	(25,848)	124,719
Accrued expenses and other current liabilities	188,767	279,840
Refundable advance	(442,580)	578,105
Net cash provided by operating activities	598,319	833,078
Cash flows from investing activities		
Purchases of property and equipment	(971,503)	(353,541)
Net cash used in investing activities	(971,503)	(353,541)
Cash flows from financing activities		
Proceeds on short-term note payable	-	484,000
Proceeds on long-term debt	-	1,268,000
Government grants for capital acquisitions	148,325	-
Payments on long-term debt	(164,185)	(162,371)
Capitalized debt issuance costs	(29,338)	-
Payments on capital leases	-	(591)
Net cash provided by (used in) financing activities	(45,198)	1,589,038
Net increase (decrease) in cash, cash equivalents and restricted cash	(418,382)	2,068,575
Cash, cash equivalents and restricted cash, beginning of year	3,902,487	1,833,912
Cash, cash equivalents and restricted cash, end of year	$ 3,484,105	$ 3,902,487

The accompanying notes to financial statements are an integral part of these statements.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidated Statements of Cash Flows (continued)

For the Years Ended June 30, 2021 and 2020

Cash, cash equivalents and restricted cash consisted of the following as of June 30:

	2021	2020
Cash and cash equivalents	$ 3,392,262	$ 3,823,909
Restricted cash	91,843	78,578
	$ 3,484,105	$ 3,902,487

Supplemental Disclosures of Cash Flow Information

	2021	2020
Cash payments for:		
Interest	$ 198,195	$ 195,518

Supplemental Disclosures of Non-Cash Transactions

During 2021, the Organization acquired a building and refinanced two previously held loans on property through the issuance of a long-term note payable in the amount of $2,350,000.

During 2021, the Organization acquired an additional building through the issuance of a long-term note payable in the amount of $960,000.

During 2021, the Organization applied for and was approved for the conversion of its outstanding COVID-19 Emergency Healthcare System Relief Fund Loan through the State of New Hampshire in the amount of $484,000 into grant income (see Notes 4 and 8).

During 2020, the Organization acquired land through the issuance of a long-term note payable in the amount of $95,000.

The accompanying notes to financial statements are an integral part of these statements

1. The Organization and Summary of Significant Accounting Policies:

Organization

Mid-State Health Center ("MSHC") is a Federally Qualified Health Center (FQHC) which provides health care to a large number of Medicare, Medicaid and charity care patients on an outpatient basis. MSHC maintains facilities in Plymouth and Bristol, New Hampshire.

The consolidated financial statements include the accounts of Mid-State Community Development Corporation (MSCDC), collectively, "the Organization". Effective September 23, 2010, the Organization was transferred a sole member interest in MSCDC, which owns the 19,500 square foot operating facility that was developed to house the Organization, providing medical services to the underserved community in the Plymouth, New Hampshire region.

Use of Estimates

The Organization uses estimates and assumptions in preparing financial statements in accordance with accounting principles generally accepted in the United States of America. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities and the reported revenues and expenses. Actual results could differ from those estimates.

Basis of Statement Presentation

The consolidated financial statements are presented on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America. The consolidated financial statements have been prepared consistent with the American Institute of Certified Public Accountants *Audit and Accounting Guide, Health Care Organizations* (Audit Guide). All significant intercompany transactions between MSHC and MSCDC have been eliminated in consolidation.

Classes of Net Assets

The Organization reports information regarding its consolidated financial position and operations to two classes of net assets; net assets without donor restrictions and net assets with donor restrictions, based on the existence or absence of donor-imposed restrictions.

Net Assets Without Donor Restrictions - Include net assets available for use in general operations and not subject to donor restrictions.

Net Assets With Donor Restrictions - Include net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time - such as promises to give - or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. As of June 30, 2021, the Organization had restrictions that were temporary in nature due to implied time restrictions on promises to give due in future periods. When an implied time restriction ends or purpose restriction is satisfied, net assets with door restriction are reclassified to net assets without donor restriction and are reported on the consolidated statements of operations as net assets released from donor restrictions. The Organization has elected the "simultaneous release" accounting policy option, such that, conditional contributions received whose condition lapses simultaneously with the expiration of donor-imposed use restrictions are reported in net assets without donor restrictions. Additionally, unconditional contributions received and who donor-imposed use restriction is satisfied within the same period are reported in net assets without door restriction.

1. The Organization and Summary of Significant Accounting Policies (continued):

Cash and Cash Equivalents

Cash and cash equivalents are defined as cash and short-term investments with an original maturity of three months or less from the date of purchase.

Cash in Excess of FDIC-Insured Limits

The Organization maintains its cash in bank deposit accounts which, at times, may exceed federally insured limits. Accounts are generally guaranteed by the Federal Deposit Insurance Corporation (FDIC) up to certain limits. The Organization has not experienced any losses in such accounts.

Patient Services Receivable

Patient services receivable result from the health care services provided by the Organization. Patient services receivable are recorded at net realizable value at the transaction price based on standard charges for services provided, reduced by both implicit and explicit price adjustments provided to third-party payors. Sliding fee scale, explicit price concession, is offered to uninsured patients if they are eligible in accordance with the Organization's policies, or implicit price concessions if collection is not expected to be collected on the patient portion, and/or implicit price concessions provided to uninsured or underinsured patients, and do not bear interest. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient revenues in the period of the change.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Property and equipment donated for Organization operations are recorded at fair value at the date of receipt. Expenditures for repairs and maintenance are expensed when incurred and betterments are capitalized.

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under capital leases is amortized on the straight-line method over the life of the capital lease. Such amortization is included in depreciation and amortization in the financial statements.

Estimated useful lives are as follows:

	YEARS
Buildings	5 - 40
Leasehold improvements	5
Equipment	3 - 7
Furniture and fixtures	5 - 15
Capital leases	3 - 15

The Organization reviews the carrying value of property and equipment for impairment whenever events and circumstances indicate that the carrying value of an asset may not be recoverable from the estimated future cash flows expected to result from its use and eventual disposition. In cases where undiscounted expected future cash flows are less than carrying value, an impairment loss is recognized equal to an amount by which the carrying value exceeds the fair value of assets. The factors considered by management in performing this assessment include current operating results, trends and prospects, as well as the effects of obsolescence, demand, competition and other economic factors.

1. The Organization and Summary of Significant Accounting Policies (continued):

Net Patient Services Revenue

Net patient services revenue is recognized at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed. Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by the Organization. Revenue for performance obligations satisfied at a point in time are recognized when services are provided, and the Organization does not believe it is required to provide additional services to the patient. The Organization determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors. Sliding fee scale is offered to uninsured patients if they are eligible in accordance with the Organization's policy. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

The Organization applies the following practical expedients provided in Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606, *Revenue from Contracts with Customers*, to its contracts with patients:

(i) The Organization applies the portfolio approach as a practical expedient allowed under ASC Subtopic 606-10-10-4 to account for most of its patient contracts as a collective group rather than on an individual basis. The Organization does not expect the impact to the consolidated financial statements, when applying the revenue recognition guidance for patient services revenue, to differ materially using the portfolio approach rather than if applied at an individual contract level.

(ii) The Organization has elected the practical expedient allowed under ASC Subtopic 606-10-32-18 to not adjust the transaction price for the effects of a significant financing component, as payment is expected to be received from patients and third-party payors within one year from the date the patient receives services.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy with minimal charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue or included in patient services receivable.

Determination of eligibility for charity care is granted on a sliding fee basis. Patients with family income less than 100% of the Community Services Administration Income Poverty Guidelines shall only be responsible for a nominal fee assessed by the Organization and not the balance of their account for services received. Those with family income at least equal to 101%, but not exceeding 125% of the Federal Poverty Guidelines, receive a 65% discount. Those with family income at least equal to 126%, but not exceeding 150% of the guidelines, receive a 55% discount. Those with family income at least equal to 151%, but not exceeding 200% of the guidelines, receive a 45% discount.

The Organization maintains records to identify and monitor the level of charity care they provide. These records include the amount of charges foregone for services and supplies furnished under their charity care policies. The total cost estimate is based on an overall cost-to-charge ratio applied against gross charity care charges. The net cost of charity care provided was approximately $311,000 and $370,000 for the years ended June 30, 2021 and 2020, respectively.

1. The Organization and Summary of Significant Accounting Policies (continued):

Government Grant Revenue

Government grants, consisting of federal, state and local grants, are primarily considered to be conditional contribution transactions, the majority of which are cost-reimbursement grants. The Organization has elected the "simultaneous release" accounting policy option, such that, conditional contributions received whose condition lapses simultaneously with the expiration of donor-imposed use restrictions are reported in net assets without donor restrictions. The Organization's costs incurred under its government grants are subject to audit by government agencies. Management believes the disallowance of costs, if any, would not be material to the consolidated financial position or consolidated statement of operations.

Revenue from government grants considered to be exchange transactions are included under the caption "contracted services" on the Organization's consolidated statement of operations.

Contract Revenue

The Organization has entered into various service agreements considered to be exchange transactions. Significant items included in contracted services include:

(i) The Organization participates in the 340B Drug Discount Program which enables qualifying entities to purchase drugs from pharmaceutical suppliers at a substantial discount. The 340B Drug Discount Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs. The Organization earns revenue under this program by purchasing pharmaceuticals at a reduced cost to fill prescriptions to qualified patients. The Organization has a network of participating pharmacies that dispense the pharmaceuticals to its patients under contract arrangements with the Organization. Reported 340B revenue consists of the gross pharmacy reimbursements. Pharmacy and third-party administrator fees are included in expenses. The 340B expenses are included in supplies and expenses (See Note 14).

(ii) The Organization has contracted with a third-party to provide managed in-house infusion services.

(iii) The Organization enters into purchased services agreements. The agreements generally are with certain organizations who purchase services of personnel employed by the Organization. Contracted service revenue is earned over time, utilizing an output method, as the Organization provides the service. The transaction price is negotiated with the customer and is usually based on standard hourly rates for the service, based on the respective personnel utilized. Revenue pursuant to these agreements have been classified as "contracted services" on the Organization's consolidated statement of operations.

Other Operating Revenue

The Organization recognizes other operating revenue central to day-to-day operations primarily consisting of revenue from the Organizations child care center, rental of space within its facility by individuals and organizations providing services in a medical related field, quality incentive income and other miscellaneous service reimbursements not directly related to patient care.

Contributions

Contributions are recognized at the earlier of when cash is received or at the time a promise becomes unconditional in nature. Contributions are recorded in the net asset classes described earlier depending on the existence and/or nature of any donor-imposed restriction.

1. The Organization and Summary of Significant Accounting Policies (continued):

Income Taxes

MSHC and MSCDC are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (Code) and are exempt from Federal income taxes on related income pursuant to Section 501(a) of the Code.

The Organization accounts for its uncertain tax positions in accordance with the accounting methods under ASC Subtopic 740-10. The UTP rules prescribe a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken in an organization's tax return. The Organization believes that it has appropriate support for the tax positions taken and, as such, does not have any uncertain tax positions that might result in a material impact on the Organization's statements of financial position, operations and changes in net assets and cash flows. The Organization's management believes it is no longer subject to examinations for the years prior to 2017.

Advertising

Advertising costs are charged to operations when incurred. Total advertising expense for the years ended June 30, 2021 and 2020 was $56,412 and $35,871, respectively.

Functional Allocation of Expenses

Expenses that can be identified with specific program or supporting services are charged directly to the related program or supporting service. Expenses that are associated with more than one program or supporting service are allocated based on an evaluation by management utilizing measurements for time and effort, square footage and/or encounter based statistics.

Operating Income (Loss)

The consolidated statements of operations includes a determination of operating income (loss). The Organization considers all of its health care and related activities to be part of normal operations and considers the caption "operating income (loss)"to be its performance indicator. Changes in net assets without restrictions which are excluded from excess (deficit) of revenues over expenses, consistent with industry practice, include contributions and grants of long-lived assets.

Changes in net assets without donor restrictions, which are excluded from operating income (loss), includes contributions for long-lived assets (including assets acquired using contributions, which by donor restriction were used for the purpose of acquiring such assets) and infrequent transactions.

Fair Value of Financial Instruments

The carrying amount of cash, patient services receivable, accounts and notes payable and accrued expenses approximates fair value.

Reclassifications

Certain reclassifications have been made to the prior year's financial statements to conform to the current year presentation. These reclassifications have no effect on the previously reported change in net assets.

1. The Organization and Summary of Significant Accounting Policies (continued):

Liquidity

Assets are presented in the accompanying consolidated statements of financial position according to their nearness of conversion to cash and liabilities according to the nearness of their maturity and resulting use of cash.

Accounting Pronouncement Adopted in the Current Year

In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers* (ASC 606). ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Organization adopted ASU 2014-09 in 2021 under the full retrospective method. Additionally, the Organization applied the practical expedients to account for revenues with similar characteristics as a collective group rather than individually, to not adjust the transaction price for effects of a significant financing component, and to not disclose the transaction price allocated to unsatisfied or partially unsatisfied performance obligations as of the end of the reporting period when the performance obligations relate to contracts with an expected duration of less than one year. The adoption of ASU 2014-09 did not materially impact the timing or amount of revenue recognized by the Organization in the consolidated financial statements. Accordingly, the Organization's 2020 consolidated statements of activities has been revised to the 2021 presentation.

Accounting Pronouncements Issued and Not Yet Adopted

In February 2016, the FASB issued ASU 2016-02, *Leases*, to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. The update is effective for financial statements issued for fiscal years beginning after December 15, 2021 with early adoption permitted, using a modified retrospective approach. The Organization has not elected early adoption of the provisions of ASU 2016-02 and is evaluating its impact.

In September 2020, the FASB issued ASU 2020-07, *Not-for-Profit Entities: Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets*. The ASU requires contributed nonfinancial assets to be presented as a separate line item in the statement of activities, apart from contributions of cash and other financial assets; to disclose a disaggregation of the amount of contributed nonfinancial assets recognized within the statement of activities by category that depicts the type of contributed nonfinancial assets; and certain additional disclosures for each category of contributed nonfinancial assets recognized including whether the nonfinancial assets were either monetized or utilized during the reporting period, the not-for-profit's policy about monetizing rather than utilizing, a description of any donor-imposed restrictions and a description of the valuation techniques and inputs used to arrive at a fair value measure. The ASU is effective for annual periods beginning after June 15, 2021, with early adoption permitted, and should be applied on a retrospective basis. The Organization has not elected early adoption of the provisions of ASU 2020-07 and is evaluating its impact.

2. Patient Services Revenue and Patient Services Receivable:

Patient services revenue, net of explicit and implicit price concessions, consisted of the following for the years ended June 30:

	2021	2020
Gross patient services revenue	$ 11,240,538	$ 10,141,118
Less: explicit and implicit price concessions	(3,105,671)	(3,095,544)
Net patient services revenue	$ 8,134,867	$ 7,045,574

Patient services receivable results from the health care services provided by the Organization. Patient services receivable are recorded at net realizable value at the transaction price based on standard charges for services provided, reduced by: (1) both contractual (explicit) and implicit price adjustments provided to third-party payors, (2) sliding fee scale adjustments (explicit price concessions) offered to uninsured or underinsured patients if they meet the Organization's eligibility policies, (3) implicit price concessions if collection is not expected to occur for some or all of the patient portion and (4) other implicit price concessions provided to uninsured or underinsured patients. Patient services receivable do not bear interest. Subsequent changes to the estimate of the transaction price are generally recorded as an adjustment to patient services revenue in the period of change.

Patient services receivable, net of explicit and implicit price concessions, was as follows as of June 30:

	2021	2020
Gross patient services receivable	$ 2,035,177	$ 1,234,960
Less: explicit and implicit price concessions	976,521	588,689
Patient services receivable, net	$ 1,058,656	$ 646,271

3. Estimated Third-Party Settlements:

Provision has been made for estimated adjustments that may result from final settlement of reimbursable amounts as may be required upon completion and audit of related cost finding reports under terms of contracts with the Center for Medicare and Medicaid Services and the New Hampshire Division of Welfare (Medicaid). Differences between estimated adjustments and amounts determined to be recoverable or payable are accounted for as income or expense in the year that such amounts become known.

4. Government Grants Receivable:

The Organization receives various reimbursement grants from the federal government, State of New Hampshire and other public agencies considered to be conditional contributions (see Note 1). The following is a summary of the grant activity for the years ended June 30:

	Government Grants Income		Government Grants Receivable	
	2021	2020	2021	2020
HRSA 330 Grant	$ 3,284,735	$ 1,901,141	$ 250,760	$ 349,500
State of NH Provider Relief Grant	484,000	-	-	-
NH Primary Care Contracts	143,322	150,794	11,946	26,675
Emergency Preparedness Grants	491,052	323,192	120,008	91,585
Provider Relief Funding	648,533	-	-	-
Bi-State Primary Care	92,986	-	92,986	-
Other government grants	118,882	110,564	7,466	-
	$ 5,263,510	$ 2,485,691	$ 483,166	$ 467,760

5. Property and Equipment:

Property and equipment consisted of the following as of June 30:

	2021	2020
Land	$ 751,173	$ 620,773
Buildings	7,519,748	6,445,703
Leasehold improvements	361,307	194,332
Furniture, fixtures and equipment	1,730,675	1,630,249
Projects in progress	704,101	-
	11,067,004	8,891,057
Less: Accumulated depreciation	3,222,225	2,912,198
	$ 7,844,779	$ 5,978,859

Depreciation and amortization expense, including amortization expense on capital lease obligations, for the years ended June 30, 2021 and 2020 amounted to $310,027 and $301,808, respectively.

6. Line of Credit:

The Organization had an available line of credit with a maximum borrowing amount of $150,000 as of June 30, 2021 and 2020, maturing December 2021. The line carries an interest rate equal to prime plus 2% (prime was 3.25% as of June 30, 2021). The line is secured by all business assets. The line was not drawn upon as of June 30, 2021 and 2020.

7. Refundable Advance:

The Organization received upfront payments of certain provider relief grant funding through the Department of Health and Human Services as a result of COVID-19 intended to cover the costs of personal protective equipment, other COVID related expenses and lost revenues attributable to COVID-19. These funds have been considered conditional, in accordance with ASU No. 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*, with a refunding requirement. The Organization is required to report its related expenditures and revenue drop to DHHS for its Period 1 payments, those received between April 10 ,2020 and June 30, 2020, on or before September 30, 2021. The Organization is further required to report its use of its Period 2 payments, those received between July 1, 2020 and December 31, 2020, to DHHS on or before December 31, 2021. Any excess qualifying expenses or revenue drop from the Organization's Period 1 reporting will be made available to carry over and be used against its Period 2 payments received. Period 1 payments totaled $578,105 and Period 2 payments totaled $205,953. For the year ended June 30, 2021, the Organization believes it satisfied the conditions placed on the Provider Relief Funding for a portion of its payments received and, as a result, recognized, as government grant income, $648,533 of its total Provider Relief Funding payments. The remaining $135,525 represented a refundable advance as of June 30, 2021. As of June 30, 2020, following the existing guidance for the Provider Relief Program, the Organization reported a refundable advance in the amount of $578,105, representing the Period 1 payments received for which the Organization had not yet overcome the existing conditions presented by the provider Relief Program guidance in place as of June 30, 2020.

8. Short-Term Debt:

The Organization entered into a COVID-19 Emergency Healthcare System Relief Fund Loan through the State of New Hampshire in the amount of $484,000. The loan was interest free with a repayment term of 180 days after the expiration of the COVID-19 state of emergency. As a component of the program, the Organization was allowed to apply for conversion of the loan into grant income. As a result of the Organization's applications provided to the State of New Hampshire, the Organization was successful on receiving approval for conversion of the loan to grant income during the year ended June 30, 2021 (see Note 4).

9. Long-Term Debt:

Long-term debt consisted of the following as of June 30:

	2021	2020
Woodsville Guarantee Savings Bank note payable, maturing August 2033, principal and interest payable in 240-monthly installments of $18,194 through August 2033. Interest is charged at a rate of 5.25%. The loan was refinanced with a Bank of NH loan in October 2020.	$ -	$ 2,072,199
United States of America Department of Agriculture note payable, maturing April 2045, principal and interest payable in 360-monthly payments of $10,904. Interest is charged at a rate of 3.5% (see Note 9a).	2,107,615	2,162,952
Meredith Village Savings Bank note payable, maturing February 2030, principal and interest payable in 120-monthly installments of $1,008. Interest is charged at a rate of 5%. Secured by certain parcels of land. The loan was refinanced with a Bank of NH loan in October 2020.	-	92,528

9. **Long-Term Debt (continued):**

	2021	2020
U.S. Small Business Administration Economic Disaster Injury Loan, maturing May 2051, principal and interest payable in 360-monthly payments of $641 commencing June 2021. Interest is charged at a rate of 2.75%.	149,359	150,000
U.S. Small Business Administration Paycheck Protection Program ("PPP") Loan, administered by Northway Bank. The loan was fully forgiven in June 2021.	-	1,118,000
Bank of NH note payable, maturing November 2031, principal and interest payable in 120-monthly installments based on a 25 year amortization of $11,918 through November 2031. At the maturity date, the entire principal balance plus interest payable will be due. Interest is charged at a rate of 3.57%.	2,315,670	-
Bank of NH note payable, maturing November 2031, principal and interest payable in 120-monthly installments based on a 25 year amortization of $4,869 through November 2031. At the maturity date, the entire principal balance plus interest payable will be due. Interest is charged at a rate of 3.57%.	945,976	-
Total long-term debt	5,518,620	5,595,679
Less: unamortized deferred financing costs	33,824	42,278
Total long-term debt, net of unamortized deferred financing costs	5,484,796	5,553,401
Less: current portion	143,471	176,509
Long-term debt, less current portion	$ 5,341,325	$ 5,376,892

9a The Organization's loan agreement requires the Organization to establish a reserve account which is to be funded in monthly installments of $1,090 until the accumulated sum of reserve funding reaches $130,848, after which no further funding is required except to replace withdrawals. As of June 30, 2021, the reserve account totaled $91,843, reflected on the consolidated statement of financial position as restricted cash.

Future maturities of long-term debt are as follows as of June 30, 2021:

2022	$ 143,471
2023	149,424
2024	154,523
2025	160,211
2026	166,186
Thereafter	4,744,805
	$ 5,518,620

10. Liquidity:

Financial assets available for general expenditures within one year of the balance sheet date consisted of the following as of June 30:

	2021	2020
Cash and cash equivalents	$ 3,392,262	$ 3,823,909
Patient services receivable, net	1,058,656	646,271
Government grants receivable	483,166	467,760
Contract and other receivables	483,643	488,718
	$ 5,417,727	$ 5,426,658

As part of its liquidity management strategy, the Organization structures its financial assets to be available as its general expenditures, liabilities and other obligations come due. The Organization has certain restricted cash balances totaling $91,843 and $78,578 as of June 30, 2021 and 2020, respectively, representing funds required to be set aside as a building maintenance reserve for the Organization's Bristol, New Hampshire location. These balances have not been included in the Organization's financial assets available for general expenditure within one year.

11. Malpractice Insurance Coverage:

The U.S. Department of Health and Human Services deemed the Organization covered under the Federal Tort Claims Act (FTCA) for damage for personal injury, including death, resulting from the performance of medical, surgical, dental and related functions. FTCA coverage is comparable to an occurrence policy without a monetary cap. Prior to being deemed for coverage under the FTCA, the Organization purchased medical malpractice insurance under a claims-made policy on a fixed premium basis. The Organization purchases primary and excess liability malpractice insurance under occurrence policies for certain services and other portions of the Organization not covered under FTCA. Claim liabilities are determined without consideration of insurance recoveries. Expected recoveries are presented separately. Management analyzes the need for an accrual of estimated losses of medical malpractice claims, including an estimate of the ultimate costs of both reported claims and claims incurred but not reported. In such cases, the expected recovery from the Organization's insurance provider is recorded within prepaid expenses and other receivables. As of June 30, 2021 and 2020, subsequent to management's assessment of potential reported and not yet reported claims, management determined that its exposure for potential unreported claims was immaterial and consequently did not provide for an accrual. It is possible that an event has occurred which will be the basis of a future material claim.

12. Retirement Program:

During 2007, the Organization adopted a tax-sheltered annuity plan under 403(b) of the Code for eligible employees. Eligible employees are specified as those who normally work more than 20 hours per week and are not classified as independent contractors. The Organization provides for matching of employee contributions, 50% of the first 6% contributed. Contributions to the plan for the years ended June 30, 2021 and 2020 were $155,133 and $159,439, respectively.

13. Health Insurance:

The Organization participates in a captive health insurance plan (Captive Plan). The Organization is subject to a stop-loss limit of $50,000 per participant in the Plan before additional coverage through the captive arrangement will commence coverage of claims. Claims submitted to the Captive Plan for reimbursement after the end of the fiscal year with service dates on or prior to June 30 are required to be recognized as a loss in the period in which they occurred. As such, the Organization has provided for a liability for unpaid claims with service dates as of or before June 30 which had not yet been reported totaling $140,315 and $66,517 as of June 30, 2021 and 2020, respectively, included under the caption "accrued expenses and other current liabilities". Effective January 2020, deductible requirements under the Captive Plan range from $1,500 to $3,500.

14. Commitments and Contingencies:

Real Estate Taxes – The Organization and the Town of Plymouth, New Hampshire agreed to a payment in lieu of real estate taxes for a period of 10 years. The agreement identified real estate taxes previously paid by the Organization to the Town that the Organization was not required to pay as a result of its tax-exempt status. The sum of the overpayments will be applied evenly on an installment basis over the 10-year period, totaling $50,000. The Organization remains subject to its requirement to timely file its application for tax exemption with the Town on an annual basis.

340B Revenue – The Organization participates in the 340B Drug Discount Program (the 340B Program) which enables qualifying health care providers to purchase drugs from pharmaceutical suppliers at a substantial discount as a Covered Entity. The 340B Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs. The Organization is required to undergo a self-audit process to determine compliance with 340B Program guidelines. The 340B statutes also explicitly authorize HRSA to audit Covered Entities to ensure they are compliant with the 340B Program. All Covered Entities are also required to recertify compliance with the 340B Program on an annual basis, including an attestation to full compliance with the 340B Program. The Organization earns revenue under the 340B Program by purchasing pharmaceuticals at a reduced cost to fill prescriptions to qualified patients. The Organization contracts with certain third-party pharmacies that dispense the pharmaceuticals to its patients. 340B revenue is included in other operating revenue within the consolidated statements of operations and totaled $1,442,783 and $1,400,403 for the years ended June 30, 2021 and 2020, respectively. The cost of pharmaceuticals, dispensing fees to the pharmacies, consulting fees and other costs associated with the 340B Program are included in operating expenses in the consolidated statements of operations and totaled $575,103 and $532,362 for the years ended June 30, 2021 and 2020, respectively.

Operating Leases – The Organization is obligated as a lessee under various operating leases. The total rent expense for operating leases related to equipment was $33,457 and $42,671 for the years ended June 30, 2021 and 2020, respectively. The following schedule details future minimum lease payments annually as of June 30, 2021 for operating leases with initial or remaining lease terms in excess of one year:

2022	$ 22,037
2023	18,364
	$ 40,401

Construction in Progress – As of June 30, 2021, the Organization purchased a future site for the Children's Learning Center. The Organization plans to renovate the building with an estimated total cost of $2,381,053. The work is expected to be completed by December 2021.

15. COVID-19:

In March 2020, the World Health Organization declared the outbreak of a novel coronavirus (COVID-19) as a pandemic and the United States Government declared COVID-19 a national emergency. The COVID-19 pandemic has impacted global markets, supply chains, business operations and community activities. Specific to the Organization, COVID-19 has impacted its emergency preparedness costs, COVID-19 control and containment activities, shortage of healthcare personnel, loss of revenue due to reductions in revenue streams as a result of declines in volume or inability to provide certain care activities. Management believes that the Organization is taking appropriate actions to respond to and mitigate any negative impact COVID-19 may present. On March 27, 2020, the President of the United States signed into law the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) to provide economic assistance to a wide array of industries to ease the financial impact of COVID-19. Significant sources of governmental assistance, including funding under the CARES Act, were as follows as of and for the years ended June 30:

	2021	2020
Recognized as government grant income:		
HRSA 330 - CARES Act Funding	$ 698,705	$ -
HRSA 330 - Expanded Capacity for COVID Testing	275,119	-
HRSA 330 - American Rescue Plan Act	250,760	-
HRSA Provider Relief Funding	648,533	-
State of NH Provider Relief	484,000	-
GOFERR COVID Funding	37,235	-
CARES Act benefits included in government grant income	2,394,352	-
Recognized as nonoperating income:		
Paycheck Protection Program debt forgiveness	1,118,000	-
CARES Act benefits included in increase (decrease) in net assets	$ 3,512,352	$ -
Liabilities reported:		
Refundable Advance - Provider Relief Funding	$ 135,525	$ 578,105
Economic Injury Disaster Loan	149,359	150,000
Paycheck Protection Program loan	-	1,118,000
Advance payments and long-term debt in total liabilities	$ 284,884	$ 1,846,105

16. Concentration of Credit Risk:

The Organization grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors was as follows at June 30:

	2021	2020
Medicare	21.5%	13.1%
Medicaid	17.2%	20.0%
Blue Cross	20.9%	15.6%
Patients	18.4%	22.3%
Other third-party payors	22.0%	29.0%
	100.0%	100.0%

17. Subsequent Events:

The Organization has reviewed events occurring after June 30, 2021 through November 18, 2021, the date the board of trustees accepted the final draft of the consolidated financial statements and made them available to be issued.

In July 2021, the Organization received a CDFA Tax Credit Program award of up to $300,000 in tax credits which will net $240,000 for the Children's Learning Center expansion project. The CDFA Tax Credit Program will allocate $150,000 for the years ending June 30, 2022 and 2023.

In July 2021, the Organization was awarded a $1,960,000 construction loan for its Children's Learning Center expansion project, bearing interest at 4.25%, maturing January 2033.

In August 2021, the Organization received approval from the U.S. Department of Agriculture for a $1,995,000 community facilities loan for its Children's Learning Center expansion project.

In August 2021, the Organization was awarded a $350,000 State Economic & Infrastructure Development (SEID) grant through the Northern Border Regional Commission Board ("NBRC") for the Children's Learning Center expansion Project.

In September 2021, the Organization entered into a purchase and sale agreement for Unit #2 of its Plymouth, New Hampshire operating facility in the amount of $750,00. The agreement calls for cash payments totaling $150,000 and an installment note for $600,000. The installment note calls for five annual payments of $120,000 plus interest at a rate of 3.25%.

MID-STATE HEALTH CENTER
Schedule of Expenditures of Federal Awards
For the Year Ended June 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Federal Assistance Listing Number	Pass-through Entity or Award Identifying Number	Federal Expenditures	Provided to Subrecipients
U.S. Department of Health and Human Services:				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		$ 2,060,151	$ -
COVID-19 Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		1,224,584	-
COVID-19 Provider Relief Fund	93.498		578,519	-
Passed through Bi-State Primary Care Association, Inc.				
Opioid STR	93.788	FAIN TI081685	92,986	-
Passed through Community for Alcohol and Drug Free Youth, Inc.				
Rural Health Care Services Outreach, Rural Health Network Development and Small Health Care Provider Quality Improvement	93.912	Unknown	42,113	-
Passed through N.H. Department of Health and Human Services:				
Block Grants for Prevention and Treatment of Substance Abuse	93.959	FAIN #TI083041	91,939	-
Immunization Cooperative Agreements	93.268	FAIN NH23IP922595	46,801	-
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074 Comprised of 93.889 & 93.069	FAIN NU90TP922018 FAIN U3REP190580	66,595	-
Maternal and Child Health Services Block Grant to the States	93.994	Unknown	37,264	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	FAIN SP020796	79,428	-

MID-STATE HEALTH CENTER
Schedule of Expenditures of Federal Awards (Continued)
For the Year Ended June 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Federal Assistance Listing Number	Pass-through Entity or Award Identifying Number	Federal Expenditures	Provided to Subrecipients
Public Health Emergency Response: Cooperative Agreement for Emergency Response:				
Public Health Crisis Response	93.354	FAIN NU90TP922106	49,979	-
Preventive Health and Health Services Block Grant	93.991	FAIN NB01OT009381-01-00	23,823	-
Environmental Public Health and Emergency Response	93.070	FAIN NUE1EH001357	8,936	-
Total passed through N.H. Department of Health and Human Services			404,765	-
Total U.S. Department of Health and Human Services			4,403,118	-
U.S. Department of the Treasury:				
Passed through Governor's Office for Emergency Relief and Recovery				
COVID-19 Coronavirus Relief Fund	21.019	Unknown	484,000	-
COVID-19 Coronavirus Relief Fund	21.019	020487172	12,088	-
Total passed through Governor's Office for Emergency Relief and Recovery			496,088	-
Passed through Governor's Office for Emergency Relief and Recovery and Health Strategies Of NH				
COVID-19 Coronavirus Relief Fund	21.019	Unknown	21,835	-
Total COVID-19 Coronavirus Relief Fund			517,923	-
Total U.S. Department of the Treasury:			517,923	-
U.S. Department of Homeland Security				
Passed through N.H. Department of Health and Human Services:				
COVID-19 Disaster Grants-Public Assistance (Presidentially Declared Disasters)	97.036	FAIN 4516DRNHP00000001	100,000	-
Total U.S. Department of Homeland Security			100,000	-
TOTAL EXPENDITURES OF FEDERAL AWARDS			$ 5,021,041	$ -

The accompanying notes to financial statements are an integral part of this schedule.

MID-STATE HEALTH CENTER

Notes to Schedule of Expenditures of Federal Awards

For the Year Ended June 30, 2021

1. Basis of Presentation:

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) includes the federal award activity of MSHC under programs of the federal government for the year ended June 30, 2021. The information in the schedule is presented in accordance with the requirements of Title 2 US. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). Since the schedule presents only a selected portion of the operations of MSHC, it is not intended to and does not present the statement of financial position, statement of operations and changes in net assets or cash flows of MSHC.

2. Significant Accounting Policies:

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. The Schedule includes Catalog of Federal Domestic Assistance (CFDA) and pass-through award numbers when available.

3. Indirect Cost Rate:

MSHC elected to use the 10% de minimis indirect cost rate.

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Report 1

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Board of Trustees of
Mid-State Health Center:

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Mid-State Health Center ("MSHC") (a nonprofit organization), which comprise the statement of financial position as of June 30, 2021, and the related statements of operations and changes in net assets and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 18, 2021.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered MSHC's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of MHSC's internal control. Accordingly, we do not express an opinion on the effectiveness of MSHC's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* (continued)

Our consideration of the internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that have not been identified. We did identify a certain deficiency in internal control, described in the accompanying schedule of findings and questioned costs as item 2021-001, that we consider to be a material weakness.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether MSHC's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under Government Auditing Standards and which are described in the accompanying schedule of findings and questioned costs as item 2021-001.

MSHC's Response to Findings

MSHC's response to the finding identified in our audit is described in the accompanying schedule of findings and questioned costs. MSHC's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Organization's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Tyler, Simms and St. Laurent, CPAs, P.C.

Lebanon, New Hampshire
November 18, 2021

TYLER, SIMMS & ST. SAUVEUR, CPAs, P.C.
Certified Public Accountants & Business Consultants

Report 2

Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance

To the Board of Trustees of
Mid-State Health Center:

Report on Compliance for Each Major Federal Program

We have audited Mid-State Health Center's ("MSHC") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of MSHC's major federal programs for the year ended June 30, 2021. MHSC's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of MSHC's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about MSHC's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of MSHC's compliance.

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Independent Auditors' Report on Compliance for Each Major Program and on Internal Control Over Compliance Required by the Uniform Guidance (continued)

Opinion on Each Major Federal Program

In our opinion, MSHC complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2021.

Report on Internal Control Over Compliance

Management of MSHC is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered MSHC's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of MSHC's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Tyler, Simms and St. Laurent, CPAs, P.C.

Lebanon, New Hampshire
November 18, 2021

MID-STATE HEALTH CENTER
Schedule of Findings and Questioned Costs
As of and For the Year Ended June 30, 2021

SECTION I - SUMMARY OF AUDITORS' RESULTS

Financial Statements

Type of auditors' report issued on whether the financial statements audited were prepared in accordance with GAAP	*Unmodified*
Internal control over financial reporting:	
Material weakness identified?	X Yes ____ No
Significant deficiencies identified that are not considered to be material weaknesses?	____ Yes X None reported
Non-compliance material to financial statements noted?	____ Yes X No

Federal Awards

Internal control over major programs:	
Material weakness identified?	____ Yes X No
Significant deficiencies identified that are not considered to be material weaknesses?	____ Yes X None reported
Type of auditors' report issued on compliance for major federal programs	*Unmodified*
Any audit findings disclosed that are required to be reported in accordance with Section 200.516(a)?	____ Yes X No

Identification of major federal programs:

Federal Assistance Listing Number	Name of Federal/Local Program
93.224	Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)
21.019	COVID-19 Coronavirus Relief Fund
93.498	COVID-19 Provider Relief Fund

Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	X Yes ____ No

SECTION II - FINANCIAL STATEMENT FINDINGS

2021-001

Criteria: A cumulative check of gross patient charges, payments and deductions by payor should be performed for year-to-date information.

Condition: During our audit procedures, we noted that reconciliations of the EMDs patient accounts receivable aging schedule, gross patient charges, payments and deductions were properly being reconciled on a monthly basis. However, we noted that a cumulative check of gross charges, payments and deductions by payor was not being performed for year-to-date information.

Effect: As a result, adjustments in a subsequent month to how charges were reported in a prior month (within EMDs) were not being identified and adjusted for in the general ledger.

Cause: The contracted billing company was not performing these cumulative checks.

Recommendation: We recommend that, in addition to running the monthly reporting to post the charge and payment activity to Blackbaud for the month, management also run and agree the year-to-date reporting out of EMDs to the year-to-date balances in Blackbaud and adjust as necessary. Further, we recommend that management investigate the cause of any changes to a prior month to identify its cause and potentially identify areas for improvement to remove or limit their occurrence in future periods.

Views of Responsible officials and planned correction action: They have since hired a new billing company and have changed accounting software that can accept imports versus having to manually enter the data, which provides staff additional time to help with the revenue tie out.

SECTION III - FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

There were no findings or questioned costs for Federal awards (as defined in Section 200.516(a) of the Uniform Guidance) that are required to be reported.

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Financial Position – Schedule 1

As of June 30, 2021

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Assets				
Current assets				
Cash and cash equivalents	$ 2,894,108	$ 498,154	$ -	$ 3,392,262
Restricted cash	91,843	-	-	91,843
Patient services receivable, net	1,058,656	-	-	1,058,656
Government grants receivable	483,166	-	-	483,166
Contract and other receivables	535,252	-	(51,609)	483,643
Promises to give	40,000	-	-	40,000
Prepaid expenses and other current assets	108,308	-	-	108,308
Total current assets	5,211,333	498,154	(51,609)	5,657,878
Long-term assets				
Property and equipment, net	2,710,141	5,134,638	-	7,844,779
Other assets	164,243	-	(121,819)	42,424
Note receivable - MSCDC	672,611	-	(672,611)	-
Total long-term assets	3,546,995	5,134,638	(794,430)	7,887,203
Total assets	$ 8,758,328	$ 5,632,792	$ (846,039)	$ 13,545,081
Liabilities and net assets				
Current liabilities				
Accounts payable	$ 301,951	$ 53,436	$ (51,609)	$ 303,778
Accrued expenses and other current liabilities	1,202,480	16,156	-	1,218,636
Refundable advance	135,525	-	-	135,525
Current portion of long-term debt	58,653	84,818	-	143,471
Total current liabilities	1,698,609	154,410	(51,609)	1,801,410
Long-term liabilities				
Lease deposits	-	121,819	(121,819)	-
Long-term debt, less current portion	2,193,132	3,148,193	-	5,341,325
Note payable - MSHC	-	672,611	(672,611)	-
Total long-term liabilities	2,193,132	3,942,623	(794,430)	5,341,325
Total liabilities	3,891,741	4,097,033	(846,039)	7,142,735
Net assets without donor restrictions	4,826,587	1,535,759	-	6,362,346
Net assets with donor restrictions	40,000	-	-	40,000
Total net assets	4,866,587	1,535,759	-	6,402,346
Total liabilities and net assets	$ 8,758,328	$ 5,632,792	$ (846,039)	$ 13,545,081

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Operations and Changes in Net Assets – Schedule 2

For the Year Ended June 30, 2021

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Operating revenues and other support without donor restrictions				
Net patient service revenues	$ 8,134,867	$ -	$ -	$ 8,134,867
Contract revenue	2,234,130	-	-	2,234,130
Other operating revenue	483,904	355,190	(329,461)	509,633
Government grants	5,115,185	-	-	5,115,185
Contributions	80,042	-	-	80,042
Total operating revenues and other support without donor restrictions	16,048,128	355,190	(329,461)	16,073,857
Operating expenses				
Salaries and wages	8,161,829	-	-	8,161,829
Employee benefits	2,339,699	-	-	2,339,699
Insurance	59,727	-	-	59,727
Professional fees	1,370,379	32,057	-	1,402,436
Supplies and expenses	2,390,638	30,845	(329,461)	2,092,022
Depreciation and amortization	180,316	129,711	-	310,027
Interest expense	75,039	126,957	-	201,996
Total operating expenses	14,577,627	319,570	(329,461)	14,567,736
Operating income	1,470,501	35,620	-	1,506,121
Nonoperating income				
Paycheck Protection Program debt discharge income	1,118,000	-	-	1,118,000
Government grants for capital acquisitions	148,325	-	-	148,325
Loss on debt refinancing	-	(34,673)	-	(34,673)
Total nonoperating income	1,266,325	(34,673)	-	1,231,652
Increase in net assets without donor restrictions	2,736,826	947	-	2,737,773
Changes in net assets with donor restrictions				
Contributions	40,000	-	-	40,000
Increase in net asset with donor restrictions	40,000	-	-	40,000
Increase in net assets	2,776,826	947	-	2,777,773
Net assets, beginning of year	2,089,761	1,534,812	-	3,624,573
Net assets, end of year	$ 4,866,587	$ 1,535,759	$ -	$ 6,402,346

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Financial Position – Schedule 3

As of June 30, 2020

	MSHC	MSCDC	ELIMINATION	TOTAL
Assets				
Current assets				
Cash and cash equivalents	$ 3,335,442	$ 488,467	$ -	$ 3,823,909
Restricted cash	78,578	-	-	78,578
Patient services receivable, net	646,271	-	-	646,271
Government grants receivable	467,760	-	-	467,760
Contract and other receivables	533,329	-	(44,611)	488,718
Prepaid expenses and other current assets	73,297	-	-	73,297
Total current assets	5,134,677	488,467	(44,611)	5,578,533
Long-term assets				
Property and equipment, net	2,623,056	3,355,803	-	5,978,859
Deposits and other assets	163,760	-	(121,578)	42,182
Total long-term assets	2,786,816	3,355,803	(121,578)	6,021,041
Total assets	$ 7,921,493	$ 3,844,270	$ (166,189)	$ 11,599,574
Liabilities and net assets				
Current liabilities				
Accounts payable	$ 329,626	$ 44,611	$ (44,611)	$ 329,626
Accrued expenses and other current liabilities	1,014,408	15,461	-	1,029,869
Refundable advance	578,105	-	-	578,105
Short-term note payable	484,000	-	-	484,000
Current portion of long-term debt	56,660	119,849	-	176,509
Total current liabilities	2,462,799	179,921	(44,611)	2,598,109
Long-term liabilities				
Lease deposits	-	121,578	(121,578)	-
Long-term debt, less current portion	3,368,933	2,007,959	-	5,376,892
Total long-term liabilities	3,368,933	2,129,537	(121,578)	5,376,892
Total liabilities	5,831,732	2,309,458	(166,189)	7,975,001
Net assets without donor restrictions	2,089,761	1,534,812	-	3,624,573
Total liabilities and net assets	$ 7,921,493	$ 3,844,270	$ (166,189)	$ 11,599,574

MID-STATE HEALTH CENTER AND SUBSIDIARY

Consolidating Statement of Operations and Changes in Net Assets – Schedule 2

For the Year Ended June 30, 2020

	MSHC	MSCDC	ELIMINATIONS	TOTAL
Operating revenues and other support without donor restrictions				
Net patient service revenues	7,045,574	-	-	7,045,574
Contract revenue	1,792,439	-	-	1,792,439
Other operating revenue	596,990	323,680	(308,211)	612,459
Government grants	2,485,691	-	-	2,485,691
Contributions	35,973	-	-	35,973
Total operating revenues and other support without donor restrictions	11,956,667	323,680	(308,211)	11,972,136
Operating expenses				
Salaries and wages	7,270,657	-	-	7,270,657
Employee benefits	1,568,194	-	-	1,568,194
Insurance	54,511	-	-	54,511
Professional fees	1,146,554	7,000	-	1,153,554
Supplies and expenses	1,999,983	2,427	(308,211)	1,694,199
Depreciation and amortization	181,189	120,619	-	301,808
Interest expense	76,997	115,853	-	192,850
Total operating expenses	12,298,085	245,899	(308,211)	12,235,773
Increase (decrease) in net assets without donor restrictions	(341,418)	77,781	-	(263,637)
Net assets, beginning of year	2,431,179	1,457,031	-	3,888,210
Net assets, end of year	$ 2,089,761	$ 1,534,812	$ -	$ 3,624,573

MID-STATE
HEALTH CENTER

— BOARD OF DIRECTORS CONTACT LIST —

BOARD OFFICERS (5)

Peter Laufenberg, President Term Exp: 6/30/23	**Todd Bickford, Vice President** Term Exp: 6/30/23	**Carina Park, Secretary** Term Exp: 6/30/22
Mike Long, Treasurer Term Exp: 6/30/22	**Timothy Naro, Immediate Past President** Term Exp: 6/30/23	

BOARD MEMBERS, ACTIVE (7)

Nicholas Coates, Director Term Exp: 6/30/24	**Isaac Davis, Director** Term Exp: 6/30/22	**Benoit Lamontagne, Director** Term Exp; 6/30/2024
Joseph Monti, Director Term Exp: 6/30/22	**Chelsea Salomon, Director** Term Exp: 6/30/24	**John Scheinman, Director** Term Exp: 6/30/24
Jarrett Stern, Director Term Exp: 6/30/2024		

BOARD MEMBERS, HONORARY (4)

Carol Bears, Director	**Ann Blair, Director**	**James Dalley, Director**
Cynthia Standing, Director		

David S. Fagan, MD

Mid-State Health Center [redacted]

Education

- University of Maryland School of Medicine, MD, 1989
- Haverford College, BA, 1985, Phi Beta Kappa

Residency

- Fletcher Allen Health Care, Burlington, VT. Internal Medicine, 1989-1992

Employment

- Mid-State Health Center, Internal Medicine, 2010-present
- Active Staff at Speare Memorial Hospital, Plymouth, NH, 2013-present
- Woodsville Internal Medicine (private practice), 1994-2010
- Woodsville Clinic, PA, Internal Medicine, 1992-1994
- Adjunct Assistant Professor of Medicine, Dartmouth Medical School, 1995-present
- Clinical Instructor, Department of Medicine, University of Vermont, 1996-2008
- Active Staff at Cottage Hospital, Woodsville, NH, 1992-2010
  - President of Hospital Medical Staff, 1994
  - President of Cottage Hospital, Inc., 1995-2005
  - Chairman, Quality Assurance Committee, 2002-2005
- Research Associate, University of Maryland School of Medicine, 1981-1985
- Research Associate, Molecular Biology, Haverford College, 1984-1985
- Teaching Assistant, Department of Biology, Haverford College, 1984-1985

License

- Board Certified in Internal Medicine, ABIM, 1997. Re-certified 2006
- Licensed to practice in New Hampshire

Memberships

- American College of Physicians, 2012-present
- New Hampshire State Medical Society, Hospital Delegate, 1992-2010
- President of Grafton County Medical Society, 1995
- Oxbow Senior Independence Program, President, 1997-1999

Honors

- William B. Chambers Community Faculty Award for Excellence in Teaching and Patient Care, Dartmouth College, 1999
- Anthem Blue Cross and Blue Shield of New Hampshire Best Practice Awards: Cervical Cancer Screening, 2000, Cervical Cancer and Diabetic Retinal Exam, 2001, Women's Health and Diabetic Care, 2002, Comprehensive Diabetic Care, 2003

Andrea M. Berry, D.O.

[redacted]

QUALIFICATIONS SUMMARY

- Professional, dedicated, self-motivated family practitioner with experience in a busy rural family practice office
- Understanding of medical issues affecting individuals and family dynamic
- Understanding and implementation of Hospice concept
- Substance Use Disorder treatment provider

PROFESSIONAL EXPERIENCE

Mid-State Health Center, Plymouth, Bristol, NH, 8/2012-present
Family Physician, Substance Use Disorder (Medication Assisted Treatment) provider
Lead clinician of Bristol office

Newfound Area Nursing Association, Bristol, NH, 3/2013-present
Hospice Medical Director

Newfound Area Nursing Association, Bristol, NH, 5/2014-present
Medical Director

University of New England College of Osteopathic Medicine, 8/2015-present
Preceptor for third and fourth year medical students for Community Health rotation

EDUCATION

University of New England College of Osteopathic Medicine, Biddeford, ME
Doctor of Osteopathic Medicine, 2009
W. Hadley Hoyt Award Recipient, 2009

Seton Hall University, South Orange, NJ
Bachelor of Science, 2003
Cum laude
Masters of Science, 2005
Summa cum laude

POSTGRADUATE TRAINING

PCOM/Heart of Lancaster Regional Medical Center, Lititz, PA
Family Medicine Resident, 6/2009 – 6/2012
Surgery and Pediatrics Department Awards, 2010
Chief Family Medicine Resident, 2011 – 2012

LICENSURE AND CERTIFICATION

NH Board of Medicine, 2011-present
BLS Certification, 2009 - present
ACLS Certification, 2009 – 2012
Buprenorphine prescriber certification/DATA2000 Waiver, 2014 - present

PROFESSIONAL MEMBERSHIPS

American College of Osteopathic Family Physicians, 2009 - present
American Academy of Family Physicians, 2011 - present
American Osteopathic Association, 2005 – present

REFERENCES

Available upon request

Cecilia L. Disney, MD

Family Medicine

[redacted]

PROFESSIONAL EXPERIENCE

Northwestern Medical Center 9/2019-present
Northwestern Primary Care and Georgia Health Center
Family Practice Physician
Georgia, VT

Sea Mar Community Health Centers- Burien Medical 9/2014-8/2019
Family Practice Physician
- Outpatient family practice with obstetrics
- Inpatient/Outpatient Attending for Swedish FM Residency

Medical Director- Burien Medical 8/2017-8/2019
Burien, WA

EDUCATION

Swedish Cherry Hill Family Medicine Residency 6/2011-6/2014
Seattle, WA
- Inpatient Co-Chief Resident

University of Pennsylvania School of Medicine 8/2007-5/2011
Philadelphia, PA
Degree: MD
- AOA, Global Health Certificate

Hamilton College 8/2003-5/2007
Clinton, NY
BA Biochemistry, Spanish Minor

LICENSURE

Vermont State expires 11/30/2022
Issued 5/01/2019
Status: Active

Washington State expires 2/3/2021
Issued: 6/19/2013
Status: Active

Board Certified 6/25/2014

DEA expires 6/30/2022
Buprenorphine- X waiver for 100 patients certified 3/2013

Information Current as of 1/30/2021

CERTIFICATIONS

CPR	expires 10/2021
ALSO	certified 7/2011
Nexplanon	certified 6/2013 updated 5/2019

PROFESSIONAL INTERESTS

Team based approach to care, population health, PCMH, Quality care metrics	
VT Asthma/COPD/Tob Collaborative	6/2020
New Medical Directors NACHC conference	1/2018
American Academy of Family Physicians Member	6/2011

HONORS AND AWARDS

Alpha Omega Alpha Honor Society	5/2011
Global Health Certificate	5/2011
Center for Public Health Initiatives Poster Contest Winner	12/2010

RESEARCH AND PAPERS PRESENTED

Center for Public Health Initiatives: Reflections on Water and Public Health — 12/2010

- *Point of Use Ceramic Water Filtration in Haiti and the Dominican Republic*

LANGUAGES

Spanish-fluent, certified medical interpreter

[redacted]

Tina Winters

FAMILY NURSE PRACTITIONER

[redacted]

SKILLS

- Highly proficient nurse with 16 years experience at the bedside in cardiac nursing, emergency medicine and critical care
- 2 years experience in Urgent Care as APRN
- Certified DOT medical examiner
- Basic EKG Interpretation
- Basic radiology interpretation
- Telemedicine experience
- Proficient in procedures including IV insertions, labs, obtaining EKGs, suturing, splinting, FB removals, I&D's and other bedside procedures

EXPERIENCE

ClearChoiceMD Urgent Care, Nurse Practitioner

November 2019-Present, Multiple Locations

- Diagnose and treats acute and minor illnesses and injuries
- Demonstrates strong physical assessment skills elicited through histories in a fast-paced, multicultural, multilingual setting
- Plans, develops and coordinates health education and counseling in response to client and community needs
- Displays high level of flexibility by diagnosing and treating multiple patient populations
- Performs DOT physicals, sports physicals, pre-employment physicals and adult wellness physicals
- Part of the Telemedicine team and provide virtual visits to UC patients. (See about 30-40 patients per day)
- Workers Compensation case experience with occupational health experience

FNP Clinical Experience/ Nurse Practitioner Student

February 2017- May 2019

Student nurse practitioner at many family practice locations in NH including Hillside Family Medicine, LRGH Convenience Care, Elliot Family Medicine and Belknap Family Health.

- Provided patient-centered, evidenced-based care to patients across the lifespan, based on best practice and current guidelines
- Engaged in all aspects of preventative, secondary and tertiary care including history taking, physical examination, diagnostics, specialist referral, prescription management, treatment plan and evaluation of interventions.
- Advised patient care based on individual preference, circumstance, age, developmental stage, family history and ethnicity
- Followed best practice to preserve patient data integrity through effective documentation with EMR

Concord Hospital, Registered Nurse
Intensive Care Unit
May 2015- July 2021, Concord, NH

- Provided nursing care to critically ill patients on a 20 bed intensive care unit
- Coordinated the assessment, diagnosis, treatment, evaluation and monitoring of critically ill patients utilizing a multi-disciplinary plan of care
- Preceptor and student preceptor providing training and guidance on nursing best practices
- Collaborate with members of the interdisciplinary team to anticipate the needs of patients
- Participated in performance improvement activities in the ICU to

Concord Hospital, Registered Nurse
Emergency Department
November 2011-April 2016

- Provided acute emergent care to a diverse population (from pediatric to across the lifespan) in the busiest ER in the state, Level 2 trauma center
- Applied expertise in prompt patient condition assessment on patient arrival in the ER during initial phases of acute illness or trauma
- Clinical Nurse 3 for ED Stroke Team Lead
- Trauma Charge RN
- Skilled in triage based on ESI level
- Precept to new clinical staff and capstone students
- SANE nurse (2013-2016)

Catholic Medical Center, Registered Nurse
Emergency Department
October 2009-November 2011, Manchester, NH

Southern NH Medical Center, Registered Nurse
Telemetry Unit
October 2003-November 2009, Nashua, NH

EDUCATION

Rivier University/ MSN in Nursing, Family Nurse Practitioner
September 2015-May 2019, Nashua, NH

Franklin Pierce University / BSN in Nursing
Graduated 2015, Rindge, NH

New Hampshire Technical Institute / Associates Degree in Nursing
Graduated 2003, Concord, NH

LICENSURE

NH Multi-State Registered Nurse: 052631-21
NH APRN License: 052631-23
AANP Certification: F07190202
BCLS /ACLS Certification: Current
DOT Certification: 9372326519
DEA: Current
NPI: 1093363194

Joseph Webb McKellar, LICSW, LLC

[redacted]

EDUCATION

University of New England, Biddeford, Maine, Masters of Social Work, May 1997
Washington & Jefferson College, Pennsylvania, Bachelor of Arts: Psychology and English May 1987
Plymouth Area High School, Plymouth, New Hampshire, June 1981

LICENSENTURE AND CERTIFICATIONS

State of New Hampshire Licensed Independent Clinical Social Worker
Certified Level I & II EMDR Practitioner

PROFESSIONAL/WORK EXPERIENCE

2013-Present **Private Practice: Joe Webb McKellar, LICSW, LLC**
50 Pleasant St. Concord, NH 03301

- Counseling families, couples, individuals, teens and children
- Work with variety of complex cases and utilize multiple approaches depending upon the needs of the client

2009-2013 **Team Leader & Case Worker at Casey Family Services, Concord, NH**

- Managed & supervised 4-6 social workers and 3 support staff in satellite office, Littleton, NH and after school program in Franklin, NH.
- Member of management team of 6 for 50+ employees with focus on staff training, development, state and federal compliance and achievement of agency's mission of services for children and families

1997-2009 **Clinical Director, Child and Family Therapist** at New England Salem Children's Trust & the Hunter School, Rumney, NH

- Supervised and managed clinical therapy department of two therapists
- Clinical supervision with direct care staff
- Coordinated adolescent psychotropic medication plans with prescribing Psychiatrist
- Managed approximately 15 cases
- Conducted individual and family therapy sessions
- Facilitated adolescent therapeutic groups
- Client assessment, mental health evaluation and diagnosis
- Development of individual treatment plans
- Court advocacy

1996-1997 **Clinical Social Work Intern** at Riverbend Community Mental Health, Concord, NH:

- Assisted with adolescents and families in the community mental health system
- Developed social skills groups for adolescents

1995-1996 **Medical Social Work Intern** at Community Home Health and Hospice, Laconia, NH:

- Worked with patients and families receiving home health care and hospice care
- Worked with local hospitals to coordinate client's discharge and future plans

1993-1997 **Clinical Family Outreach Worker & Crisis Intervention Counselor** at The Wreath School of Plymouth, NH:

- Case management of adolescent sexual offenders
- Educated and helped families of adolescent sexual offenders support treatment
- Crisis intervention and management

1992-1993 **Alternative Program Co-Teacher** at Holderness Central School, Holderness, NH

- Development and implementation of school behavior management systems

1990-1992 **Chief Instructor** at Homeward Bound Youth Forestry Camp, Brewster, MA

- Led therapeutic outdoor adventure trips for adjudicated youth

1988-1990 **Residential Teacher** at Spaulding Youth Center: Tilton, NH

- Direct care staff for abused and neglected children in residential placement

INTRESTS

Whitewater kayaking, skiing, Martial Arts, biking, dog training and raising poultry

[redacted]

Debra A Guilbert

[redacted]

Qualifications Summary

- Exceptional communication skills
- Proficient in Microsoft Word, Excel, PowerPoint, Outlook, Internet, and various Windows based software
- Outstanding ability to obtain, organize, write, edit, and prepare spreadsheets, letters, and reports.
- Skilled in coordination of events and promotions
- Proven leadership skills
- Strong scheduling and organizational skills

Professional Experience

Citizens Bank — *2004 – Present*

Licensed Banker: *Lincoln, NH 2015 – present*
Duel role as both a senior banker and licensed person holding Life and Health Insurance License and Series 6 & 63. Responsible for growing customer relationships through needs based sales of bank and investment products. Continuously exceed all sales goals and responsible for approximately $1.25 million in gross investment sales since accepting this role. Expanded on insightful listening skills, attention to detail, and adaptability to achieve all levels of customer, branch and personal goals, interpersonal skills, and more.

Senior Banker: *Lincoln, NH 2009 - 2015*
Actively market bank products to customers and potential customers. Schedule prospect appointments. Cross-sell bank products to enhance existing customer relationships. Close sales by engaging prospect in a banking relationship. Refer customer to other bank resources as appropriate for additional sales and service issues.
- 2012 Citizen of Excellence winner

Senior Teller: *Lincoln, NH* — *2008 - 2009*
Assisted teller manager in coaching staff on meeting sales goals and reporting. Assisted in maintaining branch cash supply, ordering and shipping currency. Transactional approval within senior teller authority limits.

Advanced Teller: *Lincoln, NH* — *2006 – 2008*
Supervisory approval for advanced teller levels. Responsible for branch opening and closing procedures. Supply purchasing, foreign currency management, spreadsheet development and maintenance.

Teller: *Lincoln, NH* — *2005 - 2006*
Responsible for accurately conducting transactions in compliance with bank policies and procedures. Provided excellent service to all customers, meeting teller sales referral goals. Actively participated in sales promotions.

Assistant: *Linda Knott, CFP, of CCO Investments,* — *2004 – 2005*
Assisted certified financial planner with daily tasks. Generated financial forecasts and asset allocations for clients. Kept files and sales materials compliant. Developed organizational skills, time management, and computer knowledge.

Intern: CCO Investments, NH — Spring 2004
Worked with a certified financial planner to further develop skills and knowledge gained through coursework and then apply them to a business atmosphere.

Education

Bachelor of Science in Management, Finance Focus — *May 2004*
Minor: Economics
Plymouth State University

[redacted]

Stacey Lembo

Objective

To obtain a career that will allow me to successfully integrate my skills and professional experience in position that will allow me to advance in my profession.

Education

A.S. Computer Science, Massachusetts Bay Community College, 1980
DataPoint, 1983
EASEL, 1990

Experience

2001-Present | Speare Memorial Hospital | Plymouth, NH

Patient Financial Counselor

- Assisting patients experiencing financial hardships with several options
- Evaluate patients to see if they meet the requirements for our Community Care Program, NH Health Access Program or any State and Federal programs
- Help Prenatal, post-delivery and new applicants with their applications for NH Medicaid using the NH Easy program
- Handle in house billing questions, problems and complaints

1993-1997 | EDS | Concord, NH

Provider Representative

- Worked in the EDS Title Nineteen account focused in the Provider Relations Department
- Created and Designed an on-line tracking system utilizing Excel
- Became well versed in NH Medicaid billing procedures and facilitated training via workshops in order to properly educated providers

1988-1993 | Blue Cross Blue Shield/ EDS | Boston, MA

Programmer Analyst

- Provided assistance and support to in-house personal and outside providers
- Designed, programed and tested a data entry system in Easel, a system that allowed for input of medical claims and payments from groups and subscribers

1982-1988 | Compugraphic | Wilmington, MA

Computer Programer

- Analyzed, designed, coded, tested debugging, implemented and documented both online and batch development program for the sales and marketing application
- Functions as a programmer in a production environment

[redacted]

ASHLEY MEDAS

OBJECTIVE

To obtain a position as a clinical nurse, 2.5 years of experience on a medical surgical unit while working towards a master's degree in nursing education

SKILLS & CERTIFICATIONS

Experience with Epic, Meditech & Cerner

Wound care

Dysrhythmia education

IV certification

Basic Life Support (BLS), Advanced Care Life Support (ACLS) & Pediatric Emergency Assessment, Recognition and Stabilization (PEARS)

EXPERIENCE

LAKES REGION GENERAL HOSPITAL, LACONIA NH

08/2017-present

Registered nurse – medical surgical unit

Caring for patients who have undergone general, urologic, vascular and obstetric surgeries

SOUTHPOINTE NURSING AND REHABILITATION, FALL RIVER MA

07/2015-06/2017

Certified nursing assistant

SAVOY NURSING AND REHABILITATION, NEW BEDFORD MA

01/2014-07/2015

Certified nursing assistant

TREMONT NURSING AND REHABILITATION, WAREHAM MA

07/2012-01/2014

Certified nursing assistant

EDUCATION

SOUTHERN NEW HAMPSHIRE UNIVERSITY

Currently enrolled, Master's degree of science in Nursing

UNIVERSITY OF MASSACHUSETTS DARTMOUTH

Graduation 2017, Bachelor's degree of science in Nursing

VOLUNTEER EXPERIENCE

Globe aware, Guatemala, 2015

Alyssa Hannett-Cass

Resume

[redacted]

[redacted]

Professional Goals/Objective:

Obtain a full time position to gain experience as an LPN, as well as support my educational and career goals.

Skill Highlights

- Work well with others
- Teamwork
- Multitasking
- Organized
- Outgoing personality
- Able to focus under stress
- Superb customer service skills
- Ability to maintain confidentiality

Accomplishments

- EMT Course
- Graduated from first session of NH police training cadet academy
- LNA
- BLS
- Hunters Safety/Bow education Course
- Organizing Events for Livestrong Association
- LPN

[redacted]

Professional Experience

Calamity Janes 2005-2007

Busser/Waitress- Worked as bus person/server during summer school vacation. Gained valuable customer service experience.

Plain Janes 2009-2010

Ice cream Server- Worked busy take out window, successfully keeping up with fast paced environment while maintaining positive customer relations, building upon my customer service skills.

Olympia Sports 2010-2013

Sales Associate/Key Holder- Started as sales associate and within 2 years was promoted to Key Holder position, where I served in a supervisory capacity while the Manager was off. Was responsible for cash, end of day cash reconcilement, and after hours bank deposits.

Speare Memorial Hospital 2013 - 2018

Health Unit Coordinator where I was sole administrative support for a busy Medical-Surgical Unit. Admitted/Discharged patients, maintained charts, answered patient calls. Held a position as an LNA, where I was responsible for the direct care of up to 18 patients of all ages. Taking and reporting vital signs, documenting on patient care, assisting patients will all personal needs, alerting medical staff of changes or concerns. Trained on medical surgical unit, Emergency room, and surgical services pre op/post op.

Private Duty Nursing 2018-2020

Caregiver for elderly dementia/Alzheimer's client. Assisting with daily activities and care.

Kingswood Camp- 2021 Summer Session- Present

This summer I signed a contract to work at Kingswood Camp, to counsel children of all ages. Teaching them how to safely shoot archery, camp craft, as well as perform in waterfront activities. I studied for my NCLEX here, and now that I passed, I am planning on spending time with the camp nurses here to gain some experience before the session is complete. Session ends August 15th.

Education and Training

Woodsville High - Graduated 2012

Plymouth State University- 2013: General Courses

LNA course: Grafton County

Great Brook Academy EMT course

Lakes region Community college- prerequisite nursing courses

American School of Nursing & Medical Careers- LPN program

Certifications

- CPR/BLS- Basic Life Support
- LNA- Licensed Nursing Assistant
- LPN- Licensed Practical Nurse

[redacted]

Busaba Karntakosol

[redacted]

Work Experience

Lead Medical Receptionist, Speare Primary Care, [redacted]
Speare Memorial Hospital - Plymouth, NH
2015 to 2018

[redacted]

[redacted]

- Provide exceptional customer service to Patients, Family Members & Care Takers
- Fielding incoming calls and directing calls to appropriate departments
- Utilize Nextgen Software, Meditech Software
- Implementation & utilization of Cerner Software
- Collections & processing of co-pays & patient balances
- Maintaining doctors' calendars
- Processing of patient referrals
- Surgical Scheduling
- Medical Abstracting
- Responsible for training of new employees
- Verifying & Collection of necessary insurance information to ensure accurate billing
- Assist with daily deposits
- Maintaining inventory supplies
- Opening & Closing of office

Assistant Manager
Marshall's Department Store - Plymouth, NH
2005 to 2015

03264

- Ensured customer satisfaction through employee training
- Encouraged positive attitudes to create outstanding customer experiences
- Management of 40 plus employees
- Ensure proper daily staffing
- Responsible for hiring of team members
- Processing of performance reviews
- Responsible for daily opening & closing procedures of store
- Daily Banking
- Processing of employee payroll

Assistant Store Manager

Kohls Department Store - Tilton, NH
2003 to 2005

03276

- Ensured customer satisfaction through employee training
- Management of 80 plus employees
- Ensured positive customer experiences
- Responsible for hiring of team members
- Processing of performance reviews
- Managed store payroll projections, productivity and controllable expenses in relation to sales trends
- Supervised credit solicitations to ensure store achieved its' goals
- Assisted with loss prevention in conjunction with local police
- Responsible for inventory control

Education

Bachelor Degree in Business
Bangkok Thonburi College
1993

Plymouth Regional High School
1991

Skills

Primary Care, Urgent Care, Internal Medicine

[redacted]

[redacted]

[redacted]

Crystal L. Williams

Objective

Obtain the position of Medical Receptionist with Mid State Health Center, in the Plymouth Office.

Education

1999 Laconia Technical College Laconia, NH

Business Management

Proficient in the use of all Microsoft Programs.

Business/Interpersonal Communication Skills-Certificate

Office Occupations-Certificate

2002 College For Life Long Learning
Holderness, NH

Special Education Paraprofessional Certification

Work experience

June 2004- April 2006 Stinson Mountain Grill Rumney, NH

Front of the House Manager

Duties included, but not limited to:

Scheduling, training, hiring and firing of all wait staff employees.

In charge of nightly deposits and daily cash banks.

Management for weekly inventory and pay roll for wait staff.

Responsible for opening and closing establishment.

Problem solving and direct support to owners.

August 2000- June 2004 Russell Elementary School
Rumney, NH

Special Education Paraprofessional

Duties included, but not limited to:

Provide direct support to students in a least restrictive environment.

Address concerns of parents.

Provide suggestions for accommodations and modifications for students Individual Education Program.

Provide support to teacher.

Research, write and execute sensory diets for students.

Provide direct support to students in Physical and Occupational Therapy.

Attend weekly staff meetings.

Maintain records for Medicaid reimbursement for the Students which I provided services.

Accreditations and

State of NH Paraprofessional License

Richard Prifti

Work Experience

Server/Bartender

Kathleen's Irish Pub - Bristol, NH
May 2019 to Present

- Serve tables in a multi-roomed facility including outdoor patio
- Complete food and drink orders for customers
- Assist owners/managers in keg, can and bottle inventory of beer, spirits and wine
- Maintain bar and dining room cleanliness
- Change kegs and adjust o2 tanks if necessary
- Clean Tapelines between keg changes

Drivers assistant

AMOSKEAG BEVERAGES - Bow, NH
June 2019 to September 2019

- ride with drivers to deliver beer to customer accounts including major chain and grocery store
- build pallets for Monday deliveries (night crew builds for the rest of the week)
- forklift/electric pallet jack certified
- rotate product based off date for each account
- maintain excellent work relationships with each account

Supervisor / Barback/ Door security

Trillium brewing company - Boston, MA
March 2019 to May 2019

Jobs includes:

-moving, lifting, and replacing kegs
- Knowledge of craft brewing
- Friendly customer service
- Keep bar stock
- Run glassware through washing machine
- Clean and upkeep tapelines
- Clean and upkeep bar area
- Utilize POS for orders
- (as security) monitor access points

None in Physical Education
Salem State University - Salem, MA
June 2009 to December 2010

Skills

- Key Holder
- Microsoft Office
- Training
- Team Building
- Sales
- Excel
- Inventory
- Time Management
- Management
- Filing
- POS
- Pallet Jack
- Serving Experience
- Bartending
- Forklift
- Materials Handling

Military Service

Branch: United States Navy
Rank: Petty Officer Second Class (E-5)

Certifications and Licenses

Forklift Certified
August 2019 to August 2022

7.2.7. Staffing List & Resumes

Position Title	Current Individual in Position	Hours per Week	Site
Medical Director	Fagan, David	40.00	Both
Family Medicine (& MAT)	Berry DO, Andrea	40.00	Both
Family Medicine	Disney, Cecilia	40.00	Plymouth
APRN	Winters, Tina	40.00	Bristol
LCSW	McKellar, Joseph W	40.00	Both
Quality Improvement Coordinator	Guilbert, Debra	40.00	Both
Patient Support Services (Enabling Services)	Lembo, Stacey L	40.00	Both
RN	Medas, Ashley	40.00	Bristol
RN	Hannett-Cass, Alyssa	40.00	Plymouth
Pharmacy Assistance	Karntakosol, Busaba	40.00	Both
Clinical Support - MA	Williams, Crystal	40.00	Plymouth
Integrated Health Assistant (Enabling Services)	Pirti, Richard	40.00	Both

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-09)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Weeks Medical Center		1.4 Contractor Address 173 Middle St. Lancaster, NH 03584	
1.5 Contractor Phone Number (603) 788-4911	1.6 Account Number 05-95-90-90210-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $617,806
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: Michael Lee 23AEQ0B545D5410... Date: 5/18/2022		1.12 Name and Title of Contractor Signatory Michael Lee President& CEO	
1.13 State Agency Signature DocuSigned by: Iain Watt D778BB03E9704C7... Date: 5/26/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Takhmina Rakhmatova FDF521C025C34AC... On: 6/1/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

Contractor Initials DS ML
Date 5/18/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

   1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

      3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

   1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

      12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Increase Behavioral Health Integration for Women and Children, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Well Visits for SFYs 2022-2024, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Obesity for Children & Adolescents ages 3 to 17 for SFYs 2022-2024, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

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license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.govor mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *Weeks Medical Center*

Budget Request for: *Primary Care Services*

Budget Period *G&C approval to 06/30/2022*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$24,712
2. Fringe Benefits	$0
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$24,712
Total Indirect Costs	$0
TOTAL	**$24,712**

DS

Contractor Initials ML

Date 5/18/2022

New Hampshire Department of Health and Human Services *Complete one budget form for each budget period.* **Contractor Name:** *Weeks Medical Center* **Budget Request for:** *Primary Care Services* **Budget Period** *07/01/2022 to 06/30/2023* **Indirect Cost Rate (if applicable)** 0.00%	
Line Item	**Program Cost - Funded by DHHS**
1. Salary & Wages	$296,547
2. Fringe Benefits	$0
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$296,547
Total Indirect Costs	$0
TOTAL	**$296,547**

DS

Contractor Initials ML

Date 5/18/2022

New Hampshire Department of Health and Human Services *Complete one budget form for each budget period.* **Contractor Name:** *Weeks Medical Center* **Budget Request for:** *Primary Care Services* **Budget Period** *07/01/2023 to 06/30/2024* **Indirect Cost Rate (if applicable)** 0.00%	
Line Item	**Program Cost - Funded by DHHS**
1. Salary & Wages	$296,547
2. Fringe Benefits	$0
3. Consultants	$0
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$0
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$0
5.(e) Supplies Office	$0
6. Travel	$0
7. Software	$0
8. (a) Other - Marketing/Communications	$0
8. (b) Other - Education and Training	$0
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$0
Total Direct Costs	$296,547
Total Indirect Costs	$0
TOTAL	**$296,547**

DS
Contractor Initials ML
Date 5/18/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

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Vendor Initials

5/18/2022
Date

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

DocuSigned by:
Michael Lee
23AE0B54D5400...

5/18/2022
Date

Name: Michael Lee
Title: President& CEO

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

5/18/2022
Date

DocuSigned by:
Michael Lee
23AED0B543D54D8...
Name: Michael Lee
Title: President& CEO

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Vendor Initials
5/18/2022
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

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information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

5/18/2022
Date

DocuSigned by:
Michael Lee
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Name: Michael Lee
Title: President& CEO

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Contractor Initials
5/18/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:
Michael Lee
23AED0834303408...

5/18/2022
Date

Name: Michael Lee
Title: President& CEO

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

5/18/2022
Date

DocuSigned by:
Michael Lee
Name: Michael Lee
Title: President& CEO

Contractor Initials DS ML
Date 5/18/2022

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

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e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	Weeks Medical Center
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Michael Lee
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	President& CEO
Title of Authorized Representative	Title of Authorized Representative
5/26/2022	5/18/2022
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
Michael Lee

5/18/2022
Date

Name: Michael Lee
Title: President& CEO

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 073968752

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

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Contractor Initials ML

Date 5/18/2022

the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 - Screening and Referrals for SDOH

Enabling Services Work Plan Agency Name: Weeks Medical Center Name and Role of Person(s) Completing Work Plan: Patricia A. Cotter, Grant Administrator			
Enabling Services Focus Area: Screening and Referrals for Social Determinants of Health (SDOH)			
Project Goal: Identify and Refer Patients with SDOH Concerns			
Project Objective: Obtain SDOH Information during every Wellness Visit for infants, children, adolescents, and women and identified SDOH needs referred to Case Management.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Meditech SDOH Release	• IT Department • EMR Consultant • Head of Services • Meditech (EMR)	Review in Meditech Test Mode	July 19, 2022
Meditech System Form Development and System Build	• EMR Consultant • Manager of Case Management • Director of Practice Operations • Head of Services • Meditech (EMR)	Review in Meditech Test Mode	September 1, 2022
Develop process for reporting outcomes	• Office Redesign Committee (Leadership) • IT Department • Analyzer • Meditech (EMR) • Excel	System Tracking	September 1, 2022
Front Desk Training on SDOH Responsibilities	• Patient Access Manager • Front Desk Staff • Other non-clinical staff	Staff meeting attendance and acknowledgement of training	September 1, 2022

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Attachment #1 - Screening and Referrals for SDOH

	• Meditech (EMR)		
Medical Assistant Training on SDOH Responsibilities	• Director of Practice Operations • Medical Assistants & other clinical staff • Meditech (EMR)	Staff meeting attendance and acknowledgement of training	September 1, 2022
Case Management notification of SDOH referrals	• Manager of Case Management • Case Management Staff • Meditech (EMR)	Staff meeting attendance and acknowledgement of notification	September 1, 2022
SDOH form implementation in Groveton Physicians' Office for PDSA	• Director of Practice Operations • Manager of Case Management • Practice Manager for Groveton	Plan-do-study-act (PDSA) will be used to identify problems and make improvements.	October 15, 2022
PDSA process improvements	• Director of Practice Operations • Manager of Case Management	Identify issues with process and implement improvements	October 25, 2022
Review of PDSA	• Office Redesign Committee (Leadership)	Results of PDSA	October 26, 2022
Implement process to remaining Physicians' Offices (Colebrook, Lancaster, Littleton, North Stratford, Whitefield)	• Practice Manager for Colebrook & North Stratford Office • Practice Manager for Groveton • Practice Manager for Lancaster	Provider and Staff Feedback	November 1, 2022 & on-going

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Attachment #1 - Screening and Referrals for SDOH

	• Practice Manager for Littleton & Whitefield		
Performance Measure Outcome results will be generated quarterly	• Meditech Reporting System • Grant Administrator to generate report	**Numerator:** Referrals to Case Management **Denominator:** Identified SDOH needs **Numerator/Denominator =Results (%)**	November 1, 2022 for October 2022, quarterly, biannually, annually through June 30, 2024.
Leadership Staff Review of Results & implement processes for improvements as needed	• Office Redesign Committee • Grant Administrator	Recommendations as needed	November 30, 2022

Attachment #1 - Screening and Referrals for SDOH

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

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Date _____

Attachment #1 - Screening and Referrals for SDOH

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

Attachment #1 - Screening and Referrals for SDOH

January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	
Work Plan Revisions submitted _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	

Attachment #1 - Screening and Referrals for SDOH

July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

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Attachment #2 - Increase Behavioral Health Integration for Women and Children

Enabling Services Work Plan Agency Name: Weeks Medical Center Name and Role of Person(s) Completing Work Plan: Patricia A. Cotter, Grant Administrator			
Enabling Services Focus Area: Increase Behavioral Health Integration for Women and Children			
Project Goal: Screen, Identify and Refer Patients to Behavioral Health Department			
Project Objective: Screen women and children utilizing PHQ2, PHQ9, M-Chat, PEARLS and if positive, refer patients to Weeks Medical Center's Behavioral Health Department.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Screen patients utilizing PHQ2, PHQ9, M-Chat, PEARLS, ASQ's	• All providers who serve women and children; and provider team • Meditech patient record • Structured Data Screening Tools		Currently being done and on-going
Referral to Weeks Medical Center's Behavioral Health Department for positive results	• All providers who serve women and children; and provider team • Meditech referral system • Care/Case Management Staff		Currently being done and on-going
Hire additional behavioral health providers who offer services for women and children.	• V.P. of Physician & Administrative Services • Manager of Specialty Services • Behavioral Health Provider Team • Human Resources Department • Credentialing Specialist	Interviews, selection, credentialling, verifications, licensures, etc.	May 30, 2022 and on-going
Orient new behavioral health providers	• Management team • Human Resources • Manger of Specialty Services • Preceptor	New Providers are successfully orienting per completion of competencies.	July 1, 2022

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Attachment #2 - Increase Behavioral Health Integration for Women and Children

Build new hire behavioral health providers' schedule	• Director of Practice Operations • Administrative Support • Meditech Scheduling System	Availability of providers' schedules	July 1, 2022
Schedule patients	• Schedulers • Behavioral Health Team Leader • Behavioral Health Case Manager • Front Desk • Meditech Scheduling System	Patients are being scheduled timely	July 1, 2022 & on-going
Develop EMR reporting system	• IT Department • Analyzer • Meditech Reporting System	Review in Meditech Test Mode	September 1, 2022
Performance Measure Outcome results, generated quarterly	• Grant Administrator to generate and submit reports • Meditech Reporting System • Excel	**Numerator:** Referrals to Weeks Medical Center's BH Department for treatment **Denominator:** Positive Screening **Numerator/Denominator = Results (%)**	October 1, 2022, quarterly, biannually, annually through June 30, 2024.
Leadership staff Review of Results & implement processes for improvements, as needed	• Office Redesign Committee • Grant Administrator	Recommendations as needed	October 2022
Continued Medical Education Opportunities-Weeks Funded	• All providers • Notification of Training Opportunities via o Email o Staff meeting o Mailings o Postings	Certificate of completion	Currently being done and on-going
In-service training opportunities	• All providers & staff • Healthstream-Learning Source	Certificate of completion	Currently being done and on-going

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Attachment #2 - Increase Behavioral Health Integration for Women and Children

Enabling Service Work Plan Progress Report Template Enabling Service Initiative: Project Objective:	
July 2022 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #2 - Increase Behavioral Health Integration for Women and Children

January 2023 Progress Report— • Are you on track with the Work Plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to the Work Plan, please revise and resubmit to the Department for review and/or approval. **Work Plan Revisions submitted:** _____Yes ____No	

July 2023 Project Update **SFY23 Outcome** (insert your organization's data/outcome results here for 7/1/22-6/30/23).	
Did you meet your Target/Objective?	____Yes ____No

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Attachment #2 - Increase Behavioral Health Integration for Women and Children

July 2023 Project Update **SFY23 Narrative:** If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year. **Work Plan Revisions submitted:** _____Yes ____No	
July 2023 Project Update **SFY23 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to the activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting the objective. If revisions need to be made to your work plan, please revise and resubmit to the Department for review and/or approval.	

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Attachment #2 - Increase Behavioral Health Integration for Women and Children

Work Plan Revisions submitted _____Yes ____No	
July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update **SFY24 Narrative**: If met--Explain what happened during the year that contributed to the success. If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year?	
July 2024 Project Update **SFY24 Patient Success Story**: Give an example of a patient or family who had a positive experience based on this enabling service/initiative being in place.	

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 **(July 1, 2023 – June 30, 2024)**	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 - Adolescent Well Visits for SFY 2022-2024

Quality Improvement Work Plan Agency Name: Weeks Medical Center Name and Role of Person(s) Completing Work Plan: Patricia A. Cotter, Grant Administrator			
MCH Performance Measure: Adolescent Well Visits for SFY 2022-2024			
Project Objective: Schedule adolescent well visits following episodic or acute visits to attain a 65% result for Adolescents ages 12 through 21 Years of Age who are seen for a well visit.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Create a separate document type for Well visits In Meditech (EMR), which will automatically flow into HPI for each child. Staff will easily be able to identify when the adolescent had their last WCC/CPE.	• EMR Consultant • Director of Practice Operations • Head of Service • EMR Specialist • Meditech (EMR)	Review in Meditech Test Mode	June 8, 2022
Review at the Providers' Office Practice Committee Meeting	• Head of Service • EMR Consultant • Providers • Meditech Scheduling System	Providers' feedback	June 10, 2022
Train staff at clinical and non-clinical staff meetings on new well visit type and process for determining "last well visit"	• Director of Practice Operations • Practice Manager of Colebrook & North Stratford • Practice Manager of Groveton • Practice Manager of Lancaster • Practice Manager of Littleton & Whitefield • Front Desk Staff • Scheduling Staff • Nursing Staff • Meditech Scheduling System	Staff attendance at meeting and acknowledgement of training	July 1, 2022

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Attachment #4 - Adolescent Well Visits for SFY 2022-2024

Document last well visit in the nurses note section of patient's chart	• Clinical Support Staff • Meditech Nurses Note Section		July 1, 2022
Patient Portal reminders and/or reminder calls ages 18 to 21	• Meditech Patient Portal • Volunteer Department	Minimal missed appointments	July 1, 2022
Letters to patients who have not had a scheduled well visit appointment in over one year.	• Meditech Reporting System • IT Staff to create report and an excel export • Administrative Support Staff to generate report, do a mail merge, and mail letters.		September 30, 2022
Performance Measure Outcome results will be generated quarterly.	• Meditech Reporting System • IT Staff to create report and an excel export • Analyzer • Grant Administrator to generate report	**Numerator**: All patients ages 12 through 21 who have a Weeks PCP and had a WCC /CPE if last one was > 1 year. **Denominator**: All patients ages 12 through 21 who have a Weeks PCP. **Numerator/Denominator = Results (%)**	September 30, 2022
Leadership staff Review of Results & implement processes for improvements as needed	• Office Redesign Committee (Leadership) • Grant Administrator	Recommendations, as needed	October 2022

Attachment #4 - Adolescent Well Visits for SFY 2022-2024

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #4 - Adolescent Well Visits for SFY 2022-2024

July 2023 Project Update	

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	

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Attachment #4 - Adolescent Well Visits for SFY 2022-2024

July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	
SFY24 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

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Attachment #5 - Obesity for Children & Adolescents ages 3 to 17 for SFY 2022-2024

Quality Improvement Work Plan Agency Name: Weeks Medical Center Name and Role of Person(s) Completing Work Plan: Patricia A. Cotter, Grant Administrator			
MCH Performance Measure: Obesity for children & Adolescents ages 3 to 17 for SFY 2022-2024			
Project Objective: Obtain Child/Adolescent BMI at Well Visit and document that provider counseled on nutrition and physical exercise.			
Activities: (list as many activities as are planned to reach the Objective)	Staff/Resources Involved (list for each activity)	Evaluation Plans (list as needed for each activity)	Timeline for Activity (estimated timeline for the duration of each activity)
Providers' Office Practice Committee Meeting – discuss creating a structured data question indicating that nutrition and physical education was discussed with a child/adolescent/parent/guardian or caregiver at a well visit.	• Head of Services • EMR Consultant • Director of Practice Operations • V.P. Physician & Administrative Services	Feedback from Providers	March 2022
Create a structured data question that nutrition and physical education was discussed with a child/adolescent/parent/guardian or caregiver at well visit.	• Head of Services • EMR Consultant • Director of Practice Operations • Meditech (EMR)	Review in Meditech Test Mode	March 2022
Train clinical staff to pull in structured data template	• Director of Practice Operations • Practice Manager of Colebrook & North Stratford • Practice Manager of Groveton • Practice Manager of Lancaster • Practice Manager of Littleton & Whitefield • Nursing Staff • Meditech Scheduling System	Staff attendance at meeting and acknowledgement of training	March 2022
Performance Measure Outcome results will be generated quarterly.	• Meditech Reporting System	**Numerator**: All patients ages 3 through 17 seen for	October 1, 2022

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Attachment #5 - Obesity for Children & Adolescents ages 3 to 17 for SFY 2022-2024

	• IT Staff to create report and an excel export • Analyzer • Grant Administrator to generate report	a WCC visit, discussion occurred regarding nutrition and physical education. **Denominator**: All patients ages 3 through 17 who have a Weeks PCP and who were seen for wellness visit in the measurement period. **Numerator/Denominator = Result (%)**	
Leadership staff Review of Results & implement processes for improvements as needed	• Office Redesign Committee (Leadership) • Grant Administrator	Recommendations, as needed	October 2022

Attachment #5 - Obesity for Children & Adolescents ages 3 to 17 for SFY 2022-2024

QI Work Plan Progress Report Performance Measure: Project Objective:	
July 2022 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	
January 2023 Progress Report— • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work Plan Revisions submitted:** _____Yes ____No	

Attachment #5 - Obesity for Children & Adolescents ages 3 to 17 for SFY 2022-2024

July 2023 Project Update	

SFY23 Outcome (insert your agency's data/outcome results here for 7/1/22-6/30/23)	
Did you meet your Target/Objective?	____Yes ____No
July 2023 Project Update **SFY23 Narrative**: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, AND what will be done differently to meet the target over the next year **Work Plan Revisions submitted:** _____Yes ____No	
January 2024 Progress Report: • Are you on track with the work plan as submitted? • Do any adjustments need to be made to your activities, evaluation plans or timeline? • Please give a brief update on your progress in meeting your objective. If revisions need to be made to your work plan, please revise and resubmit. **Work plan Revisions submitted:** _____Yes ____No	

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Attachment #5 - Obesity for Children & Adolescents ages 3 to 17 for SFY 2022-2024

July 2024 Project Update **SFY24 Outcome** (insert your agency's data/outcome results here for 7/1/23-6/30/24)	
Did you meet your Target/Objective?	____Yes ____No
July 2024 Project Update	
SFY24 Narrative: If met--Explain what happened during the year that contributed to the success If NOT met—what barriers were experienced, what will be done differently to meet the target over the next year	

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Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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Attachment #6 – Performance Measures

2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

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Attachment #6 – Performance Measures

2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

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Attachment #6 – Performance Measures

year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

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Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

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Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Performance Measure Name: _____ **Agency Outcome:** ___% **Agency Target:** ___%
Narrative for Not Meeting Target:
Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

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State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that WEEKS MEDICAL CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on December 22, 1919. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **63681**

Certificate Number: **0005779987**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 19th day of May A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATE OF AUTHORITY

I, Keith Young, hereby certify that:

I am a duly elected Clerk/Secretary/Officer of Weeks Medical Center

The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on May 26, 2022, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Michael D. Lee, President & CEO is duly authorized on behalf of Weeks Medical Center to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contract with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 5/31/22

Signature of Elected Officer
Name: Keith Young
Title: Chairman of the Board

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/27/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Willis Towers Watson Northeast, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	CONTACT NAME: Willis Towers Watson Certificate Center PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: certificates@willis.com
	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: ProSelect Insurance Company — 10638 INSURER B: New Hampshire Employers Insurance Company — 13083 INSURER C: INSURER D: INSURER E: INSURER F:
INSURED Weeks Medical Center 173 Middle Street Lancaster, NH 03584	

COVERAGES CERTIFICATE NUMBER: W24924676 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:			002NH000032947	10/01/2021	10/01/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ $ 1,000 $ 1,000,000 $ 3,000,000 $
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WMZ-800-8007765-2021A	10/01/2021	10/01/2022	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
A	Medical Professional Liability Claims-made			002NH000032947	10/01/2021	10/01/2022	Each Medical Incident Annual Aggregate	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

North Country Healthcare, Androscoggin Valley Hospital, North Country Home Health & Hospice Agency, Inc, Upper Connecticut Valley Hospital Association, Weeks Medical Center are named insured.

CGL & PROF is included in the same policy 002NH000032947

Certificate Holder is included as an Additional Insured as respects to General Liability, as required by written

CERTIFICATE HOLDER	CANCELLATION
State of New Hampshire, Dept. of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

AGENCY Willis Towers Watson Northeast, Inc.	NAMED INSURED Weeks Medical Center 173 Middle Street Lancaster, NH 03584
POLICY NUMBER See Page 1	
CARRIER See Page 1 / NAIC CODE: See Page 1	EFFECTIVE DATE: See Page 1

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

contract.

SR ID: 22634490 BATCH: 2542433 CERT: W24924676

Mission Statement

Weeks Medical Center's compassionate staff is committed to providing high quality and efficient health care services to ensure the well-being of our patients, families and communities.

In partnership with our communities, Weeks promotes health by;

- acknowledging that health is physical, spiritual and emotional
- emphasizing personal prevention, education and health information
- working closely with human services providers and local governments
- being closely involved with schools, businesses and churches
- actively participating in community organizations and activities
- learning about local health care needs through listening to all of our communities

Weeks strives to meet those health care needs by;

- matching our services to the needs of the individuals in our communities
- insuring timely access to health care
- providing as many services as possible locally
- delivering those services throughout our communities—in schools, businesses, homes, clinics—as well as in our modern, well-equipped Lancaster facility
- providing smoothly coordinated access to services which cannot be provided locally
- managing health care costs so that local access to health care is protected
- attracting and retaining highly trained, enthusiastic staff members
- satisfying the individuals we serve

BerryDunn

NCH north country healthcare | Weeks Medical Center

FINANCIAL STATEMENTS
and
SUPPLEMENTARY INFORMATION

September 30, 2021 and 2020
With Independent Auditor's Report

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

September 30, 2021 and 2020

Table of Contents

BerryDunn

INDEPENDENT AUDITOR'S REPORT

The Board of Trustees
Weeks Medical Center and
Lancaster Patient Care Center

We have audited the accompanying consolidated financial statements of Weeks Medical Center and Lancaster Patient Care Center (collectively, the Organization), which comprise the consolidated balance sheets as of September 30, 2021 and 2020, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Organization as of September 30, 2021 and 2020, and the results of their operations, changes in their net assets and their cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

The Board of Trustees
Weeks Medical Center and
Lancaster Patient Care Center

Other Matters

Change in Accounting Principle

As discussed in Note 2 to the consolidated financial statements, in 2021 the Organization adopted new accounting guidance, Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenues from Contracts with Customers (Topic 606)*, and related guidance. Our opinion is not modified with respect to this matter

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information included in the consolidating schedules are presented for purposes of additional analysis rather than to present the financial position and results of operations of the individual companies, and is not a required part of the consolidated financial statements. Such information is the responsibility of the management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with U.S. generally accepted auditing standards. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Berry Dunn McNeil & Parker, LLC

Manchester, New Hampshire
January 28, 2022

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidated Balance Sheets

September 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 19,395,700	$ 24,215,467
Patient accounts receivable, net	7,146,867	4,547,994
Other accounts receivable, net	763,681	477,964
Due from related parties	280,925	-
Current portion of assets limited as to use	2,872,868	2,904,910
Prepaid expenses, supplies, and other current assets	2,470,079	2,336,532
Total current assets	32,930,120	34,482,867
Assets limited as to use, excluding current portion	30,524,444	27,639,505
Note receivable	9,534,913	9,534,913
Property and equipment, net	32,929,870	33,354,188
Total assets	$ 105,919,347	$ 105,011,473

LIABILITIES AND NET ASSETS

Current liabilities		
Current portion of long-term debt	$ 638,743	$ 634,700
Accounts payable and accrued expenses	1,996,441	1,697,671
Accrued salaries and related amounts	2,795,240	1,902,210
Other current liabilities	7,855	40,117
Due to related parties	-	62,377
Medicare accelerated payments	7,351,100	10,364,323
Deferred U.S. Department of Health and Human Services (HHS) stimulus revenue	1,069,414	1,562,600
Paycheck Protection Program (PPP) refundable advance	-	4,714,095
State of New Hampshire – refundable advance	-	348,894
Deferred revenue	376,680	-
Estimated third-party payor settlements	6,886,103	5,576,075
Total current liabilities	21,121,576	26,903,062
Long-term debt, excluding current portion	21,923,099	22,500,841
Estimated third-party payor settlements	10,206,077	10,181,234
Total liabilities	53,250,752	59,585,137
Net assets		
Without donor restrictions	51,229,889	43,250,273
With donor restrictions	1,438,706	2,176,063
Total net assets	52,668,595	45,426,336
Total liabilities and net assets	$ 105,919,347	$ 105,011,473

The accompanying notes are an integral part of these financial statements.

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidated Statements of Operations

Years Ended September 30, 2021 and 2020

	2021	2020
Revenues, gains, and other support without donor restrictions		
Patient service revenue (net of contractual allowances and discounts)	$ 56,798,351	$ 52,106,519
Less provision for bad debts	-	2,110,777
Net patient service revenue	56,798,351	49,995,742
Other revenues	4,403,966	6,507,035
HHS stimulus revenue	489,474	3,715,618
Refundable advance revenue	5,062,989	-
Net assets released from restrictions for operations	84,665	86,073
Total revenues, gains and other support without donor restrictions	66,839,445	60,304,468
Expenses		
Salaries, wages and fringe benefits	35,166,324	33,174,694
Contract labor	2,513,115	1,529,067
Supplies and other	20,390,868	17,188,124
Medicaid enhancement tax	1,980,305	1,898,368
Management fee	49,770	49,750
Depreciation	3,247,849	2,250,937
Interest	541,547	569,723
Total expenses	63,889,778	56,660,663
Operating income	2,949,667	3,643,805
Nonoperating gains (losses)		
Income from investments, net	3,221,706	1,284,512
Gifts without donor restrictions, net of expenses	909	1,961
Community benefit and contribution expense	(163,825)	(59,570)
Recovery of affiliate bad debt	41,316	19,760
Net nonoperating gains, net	3,100,106	1,246,663
Excess of revenues, gains, other support, and nonoperating gains over expenses	6,049,773	4,890,468
Net assets released from restrictions for capital acquisitions	1,929,843	221,070
Increase in net assets without donor restrictions	$ 7,979,616	$ 5,111,538

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidated Statements of Changes in Net Assets

Years Ended September 30, 2021 and 2020

	Without Donor Restrictions	With Donor Restrictions	Total
Balances, October 1, 2019	$ 38,138,735	$ 2,085,740	$ 40,224,475
Excess of revenues over expenses and increase in unrestricted net assets	4,890,468	-	4,890,468
Contributions		409,025	409,025
Investment loss, net	-	(11,559)	(11,559)
Net assets released from restrictions for operations	-	(86,073)	(86,073)
Net assets released from restrictions for capital acquisition	221,070	(221,070)	-
Increase in net assets	5,111,538	90,323	5,201,861
Balances, September 30, 2020	43,250,273	2,176,063	45,426,336
Excess of revenues, gains and other support over expenses and nonoperating gains	6,049,773	-	6,049,773
Contributions	-	1,156,332	1,156,332
Investment loss, net	-	120,819	120,819
Net assets released from restrictions for operations	-	(84,665)	(84,665)
Net assets released from restrictions for capital acquisitions	1,929,843	(1,929,843)	-
Increase (decrease) in net assets	7,979,616	(737,357)	7,242,259
Balances, September 30, 2021	$ 51,229,889	$ 1,438,706	$ 52,668,595

The accompanying notes are an integral part of these financial statements.

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidated Statements of Cash Flows

Years Ended September 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	$ 7,242,259	$ 5,201,861
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	3,338,722	2,325,212
Gain on sale of equipment	(2,210)	48,870
Provision for bad debts	-	2,110,777
Realized and unrealized gains on investments	(2,149,762)	(744,803)
Refundable advance revenue	(5,062,989)	-
Decrease (increase) in		
Patient accounts receivable, net	(2,598,873)	(1,399,226)
Other accounts receivable	(285,717)	383,408
Due from related parties	(280,925)	713,772
Prepaid expenses, supplies, and other current assets	(133,547)	(141,099)
Increase (decrease) in		
Accounts payable and accrued expenses	298,770	(1,229,038)
Accrued salaries related amounts and other current liabilities	860,768	(672,783)
Due from related parties	(62,377)	67,818
Medicare accelerated payments	(3,013,223)	10,364,323
Deferred HHS stimulus revenue	(493,186)	1,562,600
Deferred revenue	376,680	-
Estimated third-party payor settlements	1,334,871	(314,159)
Net cash (used) provided by operating activities	(630,739)	18,277,533
Cash flows from investing activities		
Proceeds from sale of equipment	3,000	26,899
Purchases of property and equipment	(2,824,320)	(10,526,656)
Proceeds from sales of assets limited as to use	7,458,021	7,432,671
Purchase of assets limited as to use	(8,324,223)	(6,466,950)
Net cash used by investing activities	(3,687,522)	(9,534,036)
Cash flows from financing activities		
Proceeds from refundable advances	-	5,062,989
Repayments of long-term debt	(650,773)	(561,450)
Refund (payment) of deferred financing fees	(13,800)	2,727
Net cash (used) by financing activities	(664,573)	4,504,266
Net (decrease) increase in cash and cash equivalents	(4,982,834)	13,247,763
Cash and cash equivalents, beginning of year	24,691,683	11,443,920
Cash and cash equivalents, end of year	$ 19,708,849	$ 24,691,683
Breakdown of cash and cash equivalents and restricted cash, end of year:		
Cash and cash equivalents	$ 19,395,700	$ 24,215,467
Restricted cash included in assets limited as to use	313,149	476,216
	$ 19,708,849	$ 24,691,683
Supplemental disclosure of cash flow information		
Cash paid for interest	$ 450,674	$ 479,133

The accompanying notes are an integral part of these financial statements.

WEEKS MEDICAL CENTER AND
LANCASTER PATIENT CARE CENTER

Notes to Consolidated Financial Statements

September 30, 2021 and 2020

1. Organization

Weeks Medical Center (Hospital), a New Hampshire not-for-profit corporation, provides medical services on an inpatient and outpatient basis in Northern New Hampshire.

On June 30, 2015, the Hospital, along with three other hospitals in the North Country (Androscoggin Valley Hospital (AVH), and Upper Connecticut Valley Hospital (UCVH), signed an Affiliation Agreement. During that same week, the Boards of each of the hospitals approved the Affiliation documents which consist of an Affiliation Agreement, a Management Services Agreement, and Bylaw changes. The application to the New Hampshire Attorney General's office and Charitable Trust Unit was approved in December 2015.

Effective April 1, 2016, North Country Healthcare, Inc. (NCHI), became the sole corporate member of the Hospital. NCHI is also the parent company of AVH, UCVH, and North Country Home Health & Hospice Agency, Inc. Any and all activity with these entities is disclosed as related party transactions.

On October 2, 2018, Lancaster Patient Care Center (LPCC), a 501(c)(3) nonprofit corporation, was formed for the purpose of securing new financing related to the construction of a new LPCC on the Weeks Medical Center campus. LPCC is a wholly-controlled subsidiary of the Hospital.

2. Summary of Significant Accounting Policies

Principles of Consolidation and Reporting Entity

The consolidated financial statements include the accounts of Hospital and LPCC (collectively referred to as the Organization). Intercompany accounts and transactions have been eliminated in the consolidated financial statements.

Basis of Financial Statement Presentation

Net assets and revenues, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic (ASC) 958, *Not-for-Profit Entities*. The Organization reports information regarding its financial position and activities according the following net asset classification:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Organization. These net assets may be used at the discretion of Organization management and the Board of Trustees.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. Some donor restrictions are temporary in nature; those restrictions will be met by actions of the Organization or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Donor restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the statements of operations.

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Newly Adopted Accounting Pronouncement

In 2021, the Organization adopted FASB Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), and related guidance, which supersedes accounting standards that previously existed under U.S. generally accepted accounting principles and provides a single revenue model to address revenue recognition to be applied by all companies. Under the new standard, companies recognize revenue when a customer obtains control of promised goods or services in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods and services. ASU No. 2014-09 also requires companies to disclose additional information, including the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The Organization adopted this ASU for the year ended September 30, 2021 and elected the modified retrospective method; therefore, the consolidated financial statements and related notes have been presented accordingly. See Note 4 for adoption impact.

Cash and Cash Equivalents

Cash and cash equivalents include all cash in banks and certificates of deposit with an original maturity of three months or less, excluding amounts whose use is limited by Board designation or amounts included in net assets with donor restrictions.

Net Patient Service Revenue and Patient Accounts Receivable

Net patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed or the patient is discharged from the hospital. Revenue is recognized as performance obligations are satisfied.

The Organization has elected the practical expedient allowed under FASB ASC 606-10-32-18 and does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the Organization's expectation that the period

between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. However, the Organization does in certain instances enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Performance obligations are determined based on the nature of the services provided by the Organization. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in hospitals receiving inpatient acute care services or patients receiving services in outpatient centers. The Organization measures the performance obligation from admission into the hospital or the commencement of an outpatient service to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge or completion of the outpatient services. Revenue from performance obligations satisfied at a point in time is generally recognized when the goods are provided to patients and customers in a retail setting (for example, cafeteria) and the Organization does not believe it is required to provide additional goods or services related to that sale.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Organization has elected to apply the optional exemption provided in FASB ASC 606-10-50-14 (a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience with this class of patients and records these as a direct reduction to net patient service revenue. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and changes in commercial contractual terms resulting from contract negotiations and renewals.

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a charge to operations and a credit to a valuation allowance based on its assessment of individual accounts and historical adjustments. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to patient accounts receivable. Patient accounts receivable at October 1, 2019 was $5,259,545.

The Organization has agreements with third-party reimbursing agencies that provide for payments at amounts different from its established rates. A summary of the payment arrangements with major third-party reimbursing entities follows:

Medicare

Inpatient acute care services rendered to Medicare program beneficiaries are paid under a cost reimbursement methodology. Outpatient services are paid based on a combination of rate schedules and reimbursed cost. The Hospital is reimbursed for cost reimbursable items at an interim rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare fiscal intermediary. The Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through September 30, 2014. Revenues from the Medicare program accounted for approximately 61% of the Hospital's gross patient revenue for the years ended September 30, 2021 and 2020.

Medicaid

Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors, and are not subject to retroactive adjustment. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the fiscal intermediary. The Hospital's Medicaid cost reports have been audited by the fiscal intermediary through September 30, 2013. Revenues from the Medicaid program accounted for approximately 14% and 15% of the Hospital's gross patient revenue for the years ended September 30, 2021 and 2020, respectively.

Other

The Organization has entered into payment agreements with certain commercial insurance carriers and health maintenance organizations. The basis for payment to the Organization is primarily prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result of investigations by governmental agencies, various healthcare organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Hospital's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Hospital. In addition, the contracts the Hospital has with commercial and other payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Organization's historical settlement activity, including a determination it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from changes in transaction price in 2021 and 2020 increased net patient service revenue by approximately $2,698,000 and $2,682,000, respectively.

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represents the difference between amounts billed to patients and the amounts the Hospital expects to collect based on its collection history with those patients.

Patients who meet the Organization's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue. The Organization estimates the costs associated with providing charity care by calculating a ratio of total cost to total gross charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of caring for charity care patients was approximately $728,000 and $718,000 for 2021 and 2020, respectively.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended September 30, 2021 and 2020 was not significant.

The Organization has determined that the nature, amount, timing, and uncertainty of revenue and cash flows are affected by the following factors:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement and payment methodologies
- Length of the patient's service or episode of care
- Method of reimbursement (fee for service or fixed prospective payment)
- Organization's program that provided the service

For the years ended September 30, 2021 and 2020, the Organization determined revenue recognized from goods and services that transfer to the customer at a point in time is not material to the consolidated financial statements.

Supplies

Supplies are carried at the lower of cost (determined by the first-in, first-out method) or net realizable value.

Assets Limited as to Use

Assets limited as to use include designated assets set aside by the Board of Trustees for future capital improvements over which the Board retains control, and which it may at its discretion subsequently use for other purposes. Also included in assets limited to use are funds set aside to fund any potential amounts owed back given the uncertainty of payments received as a disproportionate share hospital. Assets limited as to use that are designated for future capital improvements are reflected as long-term assets on the balance sheets.

Investments and Investment Income

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheets. Management has adopted FASB ASC 825-10-35-4, *Financial Instruments-Overall-Subsequent Measurement*, and has elected the fair value option relative to its investments to simplify the presentation of investment return in the statement of operations, and consolidates all investment performance activity within the nonoperating gains section of the statements of operations.

Donor-restricted investment income and gains on donor-restricted investments are recorded within net assets with donor restrictions until expended in accordance with the donor's restrictions.

Property and Equipment

Property and equipment acquisitions are recorded at cost, or if contributed, at fair market value determined at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets, such as land, buildings or equipment, are reported as support without donor restrictions unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as support with donor restrictions. The Organization reports expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Medicaid Enhancement Tax

In New Hampshire, hospitals are subject to a 5.4% tax, the Medicaid Enhancement Tax, on net taxable revenues.

Excess of Revenues, Gains, Other Support, and Nonoperating Gains Over Expenses

The statements of operations include excess of revenues, gains, other support, and nonoperating gains over expenses. Changes in net assets without donor restrictions which are excluded from this measure, consistent with industry practice, are net assets released from restrictions for capital acquisitions.

Contributions

The Organization reports gifts of cash and other assets as support with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. As donor-stipulated time restrictions end or purpose restrictions are accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of operations as net assets released from restrictions.

Contributions, including unconditional promises to give, are recognized as support in the period received. Conditional promises to give are not recognized until the conditions on which they depend are substantially met. Contributions of assets other than cash are recorded at their estimated value at the date received.

Contributions to be received after one year are discounted using a rate of interest commensurate with the risk involved for instruments of similar duration. Amortization of the discount is recorded as additional contribution revenue in accordance with donor-imposed restrictions, if any, on the contributions. An allowance for uncollectible contributions receivable is provided based upon management's judgment, including such factors as prior collection history, type of contribution, and nature of fundraising activity.

Contributions received with donor-imposed restrictions that are met in the same year as received are reported as support without donor restrictions.

Income Taxes

The Hospital and LPCC are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code, and, as such, are exempt from federal income taxes on related income.

Nonoperating Gains (Losses)

Activities, other than in connection with providing healthcare services, are considered nonoperating. Nonoperating gains and losses consist primarily of income on invested funds, gifts without donor restrictions, community benefit and contribution expense and recovery of written-off related party receivables.

PPP Refundable Advance

During 2020, the Organization qualified for and received a loan pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration (SBA) under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), in amounts totaling $4,714,095. The PPP provides funds to pay up to 24 weeks of payroll and other specified costs, and forgiveness of the loan is dependent upon compliance with this and other terms and conditions of the CARES Act. During 2021, the Organization applied for forgiveness under the provisions of the CARES Act and subsequently received the approval of the lending institution and the SBA in June 2021. The Organization had chosen in 2020 to follow the conditional contribution model for the loan, and opted to not record any income until forgiveness was received. The full amount forgiven is reported as other operating revenue in the consolidated statement of operations at September 30, 2021.

CARES Act Provider Relief Stimulus Funds

The CARES Act provided funds to eligible healthcare providers to prevent, prepare for and respond to COVID-19. The funds were appropriated to reimburse healthcare providers for healthcare related expenses or lost revenues that are attributable to COVID-19. The CARES Act provides the U.S. Department of Health and Human Services (HHS) with discretion to operate the program and determine the reporting requirements. During 2020, the Organization received $5,168,963 of HHS Provider Relief Stimulus Funds (PRF Funds) and attested to the receipt of the Funds and agreement with the associated terms and conditions. The Organization has chosen to follow the conditional contribution model for the PRF Funds. At September 30, 2021 and 2020, the Organization has recognized $489,474 and $3,715,618, respectively, of the PRF Funds in other operating revenue in the consolidated statements of operations. PRF funds of $1,069,414 are included in current liabilities on the balance sheet which were paid back to HHS as of the date of this report. Management believes the conditions on which the PRF Funds depend were substantially met. Management believes the position taken is a reasonable interpretation of the rules currently available. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, there is at least a reasonable possibility the amount of income recognized related to the lost revenues and qualifying expenses may change by a material amount. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) made available an accelerated and advance payment program to Medicare providers. The Hospital received $10,364,323 in April 2020. During 2021, CMS began recouping payment from claim payments, one year after the advance was made for a period of 17 months.

Subsequent Events

Management has considered transactions or events through January 28, 2022, which was the date the financial statements were available to be issued. Management has not considered transactions or events subsequent to this date for inclusion in the financial statements.

3. Liquidity and Availability of Financial Assets

The Organization had working capital of $11,808,544 and $7,579,805 at September 30, 2021 and 2020, respectively. The Organization had average days (based on normal expenditures) cash and cash equivalents on hand of 118 and 164 at September 30, 2021 and 2020, respectively. At September 30, 2021, cash and cash equivalents include $8,420,514 specifically related to Medicare Accelerated Payments HHS stimulus revenue and other refundable advances. This represents 52 days of cash and cash equivalents on hand.

The Organization seeks to operate with a balanced budget with the goal of generating sufficient net patient service revenue and cash flows, in addition to financial assets available to meet general expenditures over the next 12 months, to allow the Organization to be sustainable to support its mission and vision.

Financial assets and liquidity resources available within one year for general expenditure, such as operating expenses and capital construction costs not financed with debt, were as follows as of September 30:

	2021	2020
Cash and cash equivalents	$ 19,395,700	$ 24,215,467
Patient accounts receivable, net	7,146,867	4,547,994
Other receivables	763,681	477,964
	27,306,248	29,241,425
Less: donor restricted cash	(862,208)	(862,208)
Financial assets available to meet general expenditures within one year	$ 26,444,040	$ 28,379,217

The Organization has other assets limited as to use of $33,397,312 and $30,544,415 at September 30, 2021 and 2020, respectively, that are assets restricted by donors or set aside by the Board of Trustees for future capital improvements and other purposes. These assets limited as to use are not available for general expenditure within the next year; however, the internally designated amounts could be made available, if necessary.

WEEKS MEDICAL CENTER AND
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Notes to Consolidated Financial Statements

September 30, 2021 and 2020

4. Net Patient Service Revenue

Patient service revenue consists of the following for the years ended September 30:

	2021	2020
Patient services		
Inpatient	$ 11,454,429	$ 10,096,839
Outpatient	89,264,495	80,536,353
Gross patient service revenue	100,718,924	90,633,192
Less Medicare and Medicaid allowances	29,306,298	23,154,048
Less other contractual allowances	13,455,366	14,224,738
Less community care	1,158,909	1,147,887
Patient service revenue (net of contractual allowances and discounts)	56,798,351	52,106,519
Less provision for bad debts	-	2,110,777
Net patient service revenue	$ 56,798,351	$ 49,995,742

Each performance obligation is separately identifiable from other promises in the customer contract. As the performance obligations are met (i.e., room, board, ancillary services, level of care), revenue is recognized based upon the allocated transaction price. The transaction price is allocated to separate performance obligations based upon the relative standalone selling price. In instances where management determines there are multiple performance obligations across multiple months, the transaction price is allocated by applying an estimated implicit and explicit rate to gross charges based on the separate performance obligations.

In assessing collectibility, the Organization has elected the portfolio approach. This portfolio approach is being used as the Organization has a large volume of similar contracts with similar classes of customers. The Organization reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all of the contracts (which are at the patient level) by the particular payor or group of payors, will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level.

WEEKS MEDICAL CENTER AND
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Notes to Consolidated Financial Statements

September 30, 2021 and 2020

As disclosed in Note 2 to these consolidated financial statements, the Organization adopted ASU No. 2014-09 and related guidance for the year ended September 30, 2021, electing to use the modified retrospective method. Accordingly, amounts in the comparative period have not been restated and continue to be reported under the accounting standards in effect for that year. The impact of adoption on the consolidated statement of operations for the year ended September 30, 2021 follows:

	As Reported	Balance Without ASC 606 Adoption	Effect of Change
Net revenue before provision for doubtful accounts		$ 58,889,292	
Less: Provision for doubtful accounts		2,090,941	
Net revenues	$ 56,798,351	$ 56,798,351	$ -

Net patient service revenue recognized for the years ended September 30, 2021 and 2020 from these major payors is as follows:

	2021	2020
Payor:		
Medicare and Medicaid	**$ 46,482,461**	$ 44,048,744
Commercial	**9,232,640**	4,526,495
Self pay	**1,083,250**	1,420,503
Total	**$ 56,798,351**	$ 49,995,742

5. Charity Care

The Hospital maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, the estimated cost of those services and supplies and equivalent service statistics. As defined by percentage of gross revenue, 1.1% and 1.3% of all services was provided on a charity care basis for the years ended September 30, 2021 and 2020, respectively.

The Hospital provided charity care for the following number of patient admissions/visits for the years ended September 30:

	2021		2020	
	Charity	% of Total	Charity	% of Total
Inpatient admissions	**10**	**2%**	49	11%
Outpatient visits	**1,373**	**1%**	3,139	3%

6. Medicaid Enhancement Tax and Disproportionate Share Payments

Section 1923 of the Social Security Act, as amended, requires that states make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionately large numbers of low-income patients. The federal government distributes federal DSH funds to each state based on a statutory formula. The states, in turn, distribute their portion of the DSH funding among qualifying hospitals. The states are to use their federal DSH allotments to help cover costs of hospitals that provide care to low-income patients when those costs are not covered by other payors. DSH amounts recorded by the Organization are therefore subject to change upon audit, and the Organization has included a reserve of $10,206,077 and $10,181,234 in due to third-party payors at September 30, 2021 and 2020, respectively, related to potential audit and calculation adjustments. Any change in these reserves is included in the Medicare and Medicaid contractual allowances in net patient service revenue. The Organization identifies the Medicaid enhancement tax paid on net patient revenue to the State of New Hampshire as a separate expense item.

7. Property and Equipment

The major categories of property and equipment are as follows as of September 30::

	2021	2020
Land and improvements	$ 2,355,044	$ 2,355,044
Buildings	27,569,380	27,446,426
Fixed equipment – buildings and improvements	15,104,429	14,564,967
Fixed equipment – departmental	476,285	476,285
Major movable equipment	24,988,705	17,706,956
Construction in progress	176,165	5,326,916
	70,670,008	67,876,594
Less: accumulated depreciation	37,740,138	34,522,406
	$ 32,929,870	$ 33,354,188

Construction in progress as of September 30, 2021 includes approximately $50,000 of costs related to updating the laboratory of the Hospital. Total project cost is estimated to be $1,400,000 and is estimated to be complete in February 2022. The Hospital is also purchasing a new MRI which is estimated to cost $3,200,000. As of September 30, 2021 $78,000 is included in construction in progress related to the MRI purchase. The MRI is expected to be in service by August 2022. Both projects are being funded through operations.

8. Note Receivable

As part of its financing for the LPCC, the Hospital loaned $9,534,913 to Twain Investment Fund 328, LLC (Twain), an unrelated party who then invested approximately $14 million in 20 VRV 2008, LLC, another unrelated party, as part of a new markets tax credit arrangement. 20 VRV 2008 then loaned LPCC $13,581,750 as discussed in Note 10. The loan was made on November 14, 2018,

has a 30-year term, and accrues interest at 1.213%. Interest accrues monthly with interest-only payments of $9,638 due quarterly through September 2027, at which time monthly quarterly payments of $44,314, including interest, are due until the maturity date of December 10, 2047.

9. Assets Limited as to Use

Assets limited as to use consisted of the following as of September 30:

	2021	2020
Board designated – general investments	$ 23,216,530	$ 20,896,896
Board designated – designated for third party settlements	8,631,437	8,158,518
Restricted reserve	240,434	290,204
Donor restricted funds	1,308,911	1,198,797
	33,397,312	30,544,415
Less current portion	(2,872,868)	(2,904,910)
	$ 30,524,444	$ 27,639,505

The composition of assets limited as to use consisted of the following as of September 30:

	2021	2020
Mutual funds	$ 8,705,794	$ 8,173,545
Marketable equity securities	14,379,631	10,779,262
Fixed income securities	5,359,337	3,168,828
	28,444,762	22,121,635
Cash and cash equivalents and certificates of deposit	4,952,550	8,422,780
	$ 33,397,312	$ 30,544,415

Endowment

Return Objectives and Risk Parameters

The Organization has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the Organization must hold in perpetuity or for a donor-specified period. Under this policy, as approved by the Board of Trustees, the endowment assets are invested in a manner that is intended to produce results that exceed the price and yield results of the Standard & Poor's 500 index while assuming a moderate level of investment risk. The Organization expects its endowment funds, over time, to provide an average rate of return of approximately Consumer Price Index plus 2% annually. Actual returns in any given year may vary from this amount.

Strategies Employed for Achieving Objectives

To satisfy its long-term rate-of-return objectives, the Organization relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current yield (interest and dividends). The Organization targets a diversified asset allocation that places a weighted ratio on equity-based and fixed income investments to achieve its long-term return objectives within prudent risk constraints, as follows:

Common stock	30% - 70%
Fixed income	30% - 70%
Cash	0% - 20%

Appropriations are determined by the Board of Trustees from time to time.

Uniform Prudent Management of Institutional Funds Act

Effective July 1, 2008, the State of New Hampshire adopted the Uniform Prudent Management of Institutional Funds Act enacted as Revised Statutes Annotated (RSA) Chapter 292-B. This RSA provides guidance and special rules for the management of endowment funds. The Organization has interpreted this RSA to require that unexpended investment income on net assets with donor restrictions of perpetual duration is required to be reported as net assets with donor restrictions temporary in nature until expended.

Endowment (donor-restricted) net asset composition by type of fund and activity therein are as follows as of and for the years ended September 30:

	Net Assets with Donor Restrictions		
	Accumulated Appreciation of Funds of Perpetual Duration	Funds of Perpetual Duration	Total
Balances, October 1, 2019	$ 126,790	$ 911,914	$ 1,038,704
Investment return			
Investment loss, net	(5,626)	-	(5,626)
Net depreciation (realized and unrealized)	(20,294)	-	(20,294)
Total investment loss	(25,920)	-	(25,920)
Balances, September 30, 2020	100,870	911,914	1,012,784
Investment return			
Investment loss, net	**(1,874)**	-	**(1,874)**
Net appreciation (realized and unrealized)	**107,285**	-	**107,285**
Total investment gain	**105,411**	-	**105,411**
Balances, September 30, 2021	**$ 206,281**	**$ 911,914**	**$ 1,118,195**

10. Fair Value Measurement

FASB ASC 820, *Fair Value Measurement*, defines fair value as the exchange price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The standard describes three levels of inputs that may be used to measure fair value:

Level 1 – Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2 – Significant other observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3 – Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

Assets and liabilities measured at fair value on a recurring basis are summarized below.

		Fair Value Measurements at September 30, 2021	
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)
Cash and cash equivalents	$ 1,191,169	$ 1,191,169	$ -
Certificates of deposit	3,761,381	3,761,381	-
Marketable equity securities	14,379,631	14,379,631	-
Mutual funds	8,705,794	8,705,794	-
Corporate bonds	1,324,004	-	1,324,004
U.S. Treasury obligations and government securities	4,035,333	4,035,333	-
Total assets at fair value	$ 33,397,312	$ 32,073,308	$ 1,324,004

		Fair Value Measurements at September 30, 2020	
	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)
Cash and cash equivalents	$ 2,874,624	$ 2,874,624	$ -
Certificates of deposit	5,548,156	5,548,156	-
Marketable equity securities	10,779,262	10,779,262	-
Mutual funds	8,173,545	8,173,545	-
Corporate bonds	803,963	-	803,963
U.S. Treasury obligations and government securities	2,364,865	2,364,865	-
Total assets at fair value	$ 30,544,415	$ 29,740,452	$ 803,963

The fair value for Level 2 assets is primarily based on market prices of comparable securities, interest rates, and credit risk. Those techniques are significantly affected by the assumptions used, including the discount rate and estimates of future cash flows. Accordingly, the fair value estimates may not be realized in an immediate settlement of the instrument.

11. Borrowings

Long-term debt consisted of the following as of September 30:

	2021	2020
Business Finance Authority of the State of New Hampshire variable rate (2.59% at September 30, 2020) Hospital Revenue Series 2010 Bonds due September 2030. Payments are due in monthly installments of $37,000, including interest, through September 2030; collateralized by substantially all of the property and equipment of the Hospital. These bonds are held by Passumpsic Bank.	**$ 5,807,500**	$ 6,317,500
3.75% mortgage payable to Passumpsic Savings Bank, in monthly installments of $24,070, including interest, through December 1, 2038; collateralized by mortgaged property. (1)	**3,667,728**	3,808,500
Total, Hospital	**9,475,228**	10,126,000
1.0% note payable to 20 VRV 2008, LLC, a Vermont limited liability company. Interest-only payments of $3,372 are due quarterly through January 1, 2027 at which time payments of $13,777, including interest, are due quarterly until the maturity date of December 31, 2053. Collateralized by a building.	**4,046,837**	4,046,837
1.0% note payable to 20 VRV 2008, LLC, a Vermont limited liability company. Interest-only payments of $23,837 are due quarterly through January 1, 2027 at which time payments of $33,617, including interest, are due quarterly until the maturity date of December 31, 2053. Collateralized by a building.	**9,534,913**	9,534,913
Total, LPCC	**13,581,750**	13,581,750
	23,056,978	23,707,750
Less unamortized debt issuance costs	**(495,136)**	(572,209)
Less current maturities	**(638,743)**	(634,700)
	$21,923,099	$22,500,841

(1) During 2020, the Hospital amended its mortgage to Passumpsic Bank resulting in a reduction in interest rate from 5.50% to 3.75% and payment from $27,585 to $24,070 monthly. There were no additional changes in payment terms.

The bond and notes payable agreements require that the Organization meet certain covenants. As of September 30, 2021 and 2020, the Organization was in compliance with these covenants.

Estimated maturities for long-term debt in subsequent fiscal years from September 30, 2021 are as follows:

2022	$ 638,743
2023	707,295
2024	750,891
2025	757,220
2026	850,791
Thereafter	19,352,038
	$ 23,056,978

12. Retirement Plan

The Organization is part of the North Country Healthcare Retirement Plan that covers substantially all full-time employees and part-time employees who work over 1,000 hours. Contributions are computed as a percentage of earnings and are funded as accrued. The pension plan expense for the years ended September 30, 2021 and 2020 was $450,991 and $456,043, respectively.

13. Commitments and Contingencies

Liability Insurance Coverage

The Hospital insures its comprehensive general liability and professional liability exposures on a claims-made basis, including prior acts coverage, with a commercial carrier. The Hospital is subject to a claim which is in the discovery stage and for which no accrual for loss has been made as the potential for any liability is not reasonably estimable. Management believes it has meritorious defenses and will defend itself vigorously. All known significant asserted and unasserted claims alleging malpractice have been communicated to the insurer who is responsible for resolving the claim and the related costs of litigation.

GAAP requires the Hospital to accrue the ultimate cost of liability claims when the incident that gives rise to the claim occurs, without consideration of insurance recoveries. Expected recoveries are presented as a separate asset. The Hospital has evaluated its exposure to losses arising from potential claims and has accrued a liability and corresponding asset for the year ended September 30, 2021. The liability and asset are included in the balance sheet within accounts payable and accrued expenses and other current assets, respectively.

14. Net Assets with Donor Restrictions

Net assets with donor restrictions consisted of the following at September 30:

	2021	2020
Subject to expenditure for specified purpose:		
Indigent care	$ 50,834	$ 98,189
Health education	269,677	135,437
Endowment accumulated earnings	206,281	100,870
Capital campaign	-	929,653
	526,792	1,264,149
Funds invested in perpetuity for which the income is without donor restrictions	911,914	911,914
Total net assets with donor restrictions	$ 1,438,706	$ 2,176,063

During 2021 and 2020, net assets were released from donor restrictions by incurring expenditures satisfying the restricted purposes of capital acquisitions, indigent care, healthcare education and operations in the amounts of $2,014,508 and $307,143, respectively.

15. Concentration of Credit Risk

The Organization maintains cash balances at several financial institutions. Accounts at each institution are insured by the Federal Deposit Insurance Corporation up to $250,000. At times during the year, the Organization's cash in bank exceeded insured limits. The Organization has not incurred any losses from uninsured cash in bank as of September 30, 2021.

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at September 30, 2021 and 2020 was as follows:

	2021	2020
Medicare	32 %	49 %
Medicaid	11	13
Blue Cross/HMO	8	5
Other third-party payors	32	18
Patients	17	15
	100 %	100 %

WEEKS MEDICAL CENTER AND
LANCASTER PATIENT CARE CENTER

Notes to Consolidated Financial Statements

September 30, 2021 and 2020

16. Functional Expenses

The consolidated financial statements report certain categories of expenses that are attributable to more than one program or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Employee benefits are allocated based on salaries and occupancy costs are allocated by square footage. Expenses related to these functions were as follows for the years ended September 30:

2021	Healthcare Services	Support Services	Total
Salaries, wages and fringe benefits	$28,773,018	$ 6,314,256	$35,087,274
Contract labor	2,311,339	201,776	2,513,115
Supplies and other	15,059,036	5,331,832	20,390,868
Medicaid enhancement tax	-	1,980,305	1,980,305
Management fee	-	49,770	49,770
Depreciation	3,222,627	25,222	3,247,849
Interest	541,547	-	541,547
	$49,907,567	$13,903,161	$63,810,728

2020	Healthcare Services	Support Services	Total
Salaries, wages and fringe benefits	$27,518,435	$ 5,656,259	$ 33,174,694
Contract labor	1,519,194	9,873	1,529,067
Supplies and other	12,917,008	4,271,116	17,188,124
Medicaid enhancement tax	1,898,368	-	1,898,368
Management fee	-	49,750	49,750
Depreciation	2,225,415	25,522	2,250,937
Interest	569,723	-	569,723
	$46,648,143	$10,012,520	$ 56,660,663

17. Related Party Transactions

Funds have been advanced to North Country Home Health & Hospice Agency, Inc. to help fund operations. Amounts outstanding under these advances were $66,740 and $108,056 at September 30, 2021 and 2020, respectively, and are fully reserved.

WEEKS MEDICAL CENTER AND
LANCASTER PATIENT CARE CENTER

Notes to Consolidated Financial Statements

September 30, 2021 and 2020

As a member of NCHI, the Hospital shares in various services, such as shared staffing, centralized accounting, and other administrative costs, with the other member hospitals and the parent. For the year ended September 30, 2021, the Hospital billed other member hospitals $1,925,090 and was billed $3,771,433 for shared services. For the year ended September 30, 2020, the Hospital billed other member hospitals $2,372,781 and was billed $1,854,833 for shared services. Additionally, AVH paid and was reimbursed by the Hospital $4,176,822 to upgrade the Hospital's electronic medical record system.

Total expenses incurred for services provided by other members are as follows:

	2021	2020
AVH	$ 841,733	$ 667,392
UCVH	181,983	63,491
NCH	2,747,717	1,123,950
	$ 3,771,433	$ 1,854,833

Following is a summary of net amounts outstanding as receivables from (payables to) related parties. Net receivables at September 30, 2021 and 2020 are included in due from related parties and net payables in the consolidated balance sheets at September 30:

	2021	2020
AVH	$ 28,087	$ (113,099)
UCVH	79,174	25,893
NCHI	-	24,829
	$ 107,261	$ (62,377)

SUPPLEMENTARY INFORMATION

Schedule 1

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidating Balance Sheet

September 30, 2021

	Weeks Medical Center	Lancaster Patient Care Center	Eliminations	Total
Current assets				
Cash and cash equivalents	$ 19,151,580	$ 244,120	$ -	$ 19,395,700
Patient accounts receivable, net	7,146,867	-	-	7,146,867
Other accounts receivable, net	763,681	-	-	763,681
Due from related parties	280,925	-	-	280,925
Current portion of assets limited as to use	2,632,434	240,434	-	2,872,868
Prepaid expenses, supplies, and other current assets	2,470,079	-	-	2,470,079
Total current assets	32,445,566	484,554	-	32,930,120
Assets limited as to use, excluding current portion	30,524,444	-	-	30,524,444
Note receivable	9,534,913	-	-	9,534,913
Property and equipment, net	20,411,477	12,518,393	-	32,929,870
Total assets	$ 92,916,400	$ 13,002,947	$ -	$105,919,347
Current liabilities				
Current portion of long-term debt	$ 638,743	$ -	$ -	$ 638,743
Accounts payable and accrued expenses	1,996,441	-	-	1,996,441
Accrued salaries and related amounts	2,795,240	-	-	2,795,240
Other current liabilities	7,855	-	-	7,855
Medicare accelerated payments	7,351,100	-	-	7,351,100
Deferred HHS stimulus revenue	1,069,414	-	-	1,069,414
Deferred revenue	376,680	-	-	376,680
Estimated third-party payor settlements	6,886,103	-	-	6,886,103
Total current liabilities	21,121,576	-	-	21,121,576
Long-term debt, excluding current portion	8,754,211	13,168,888	-	21,923,099
Estimated third-party payor settlements	10,206,077	-	-	10,206,077
Total liabilities	40,081,864	13,168,888	-	53,250,752
Net assets (deficit)				
Without donor restrictions	51,395,830	(165,941)	-	51,229,889
With donor restrictions	1,438,706	-	-	1,438,706
Total net assets (deficit)	52,834,536	(165,941)	-	52,668,595
Total liabilities and net assets (deficit)	$ 92,916,400	$ 13,002,947	$ -	$105,919,347

Schedule 1
(Concluded)

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidating Balance Sheet

September 30, 2020

	Weeks Medical Center	Lancaster Patient Care Center	Eliminations	Total
Current assets				
Cash and cash equivalents	$ 24,014,449	$ 201,018	$ -	$ 24,215,467
Patient accounts receivable, net	4,547,994	-	-	4,547,994
Other accounts receivable, net	477,964	-	-	477,964
Current portion of assets limited as to use	2,614,706	290,204	-	2,904,910
Prepaid expenses, supplies, and other current assets	2,336,532	-	-	2,336,532
Total current assets	33,991,645	491,222	-	34,482,867
Assets limited as to use, excluding current portion	27,639,505	-	-	27,639,505
Note receivable	9,534,913	-	-	9,534,913
Property and equipment, net	20,510,642	12,843,546	-	33,354,188
Total assets	$ 91,676,705	$ 13,334,768	$ -	$105,011,473
Current liabilities				
Current portion of long-term debt	$ 634,700	$ -	$ -	$ 634,700
Accounts payable and accrued expenses	1,697,671	-	-	1,697,671
Accrued salaries and related amounts	1,902,210	-	-	1,902,210
Other current liabilities	40,117	-	-	40,117
Due to related parties	62,377	-	-	62,377
Medicare accelerated payments	10,364,323	-	-	10,364,323
Deferred HHS stimulus revenue	1,562,600	-	-	1,562,600
PPP refundable advance	4,714,095	-	-	4,714,095
State of New Hampshire – refundable advance	348,894	-	-	348,894
Estimated third-party payor settlements	5,576,075	-	-	5,576,075
Total current liabilities	26,903,062	-	-	26,903,062
Long-term debt, excluding current portion	9,414,525	13,086,316	-	22,500,841
Estimated third-party payor settlements	10,181,234	-	-	10,181,234
Total liabilities	46,498,821	13,086,316	-	59,585,137
Net assets				
Without donor restrictions	43,001,821	248,452	-	43,250,273
With donor restrictions	2,176,063	-	-	2,176,063
Total net assets	45,177,884	248,452	-	45,426,336
Total liabilities and net assets	$ 91,676,705	$ 13,334,768	$ -	$105,011,473

Schedule 2

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidating Statement of Operations

Year Ended September 30, 2021

	Weeks Medical Center	Lancaster Patient Care Center	Eliminations	Total
Revenues, gains and other support without donor restrictions				
Patient service revenue, net	$ 56,798,351	$ -	$ -	$ 56,798,351
Other revenues	4,224,966	179,000	-	4,403,966
HHS stimulus revenue	489,474	-	-	489,474
Refundable advance revenue	5,062,989	-	-	5,062,989
Net assets released from restrictions for operations	84,665	-	-	84,665
Total revenues, gains and other support without donor restrictions	66,660,445	179,000	-	66,839,445
Expenses				
Salaries, wages and fringe benefits	35,166,324	-	-	35,166,324
Contract labor	2,513,115	-	-	2,513,115
Supplies and other	20,390,788	80	-	20,390,868
Medicaid enhancement tax	1,980,305	-	-	1,980,305
Management fee	-	49,770	-	49,770
Depreciation	2,922,696	325,153	-	3,247,849
Interest	323,157	218,390	-	541,547
Total expenses	63,296,385	593,393	-	63,889,778
Operating income (loss)	3,364,060	(414,393)	-	2,949,667
Nonoperating gains (losses)				
Income from investments, net	3,221,706	-	-	3,221,706
Gifts without donor restrictions, net	909	-	-	909
Community benefit and contribution expense	(163,825)	-	-	(163,825)
Recovery of affiliate bad debt	41,316	-	-	41,316
Net nonoperating gains, net	3,100,106	-	-	3,100,106
Excess (deficiency) of revenues, gains, other support, and nonoperating gains over expenses and increase (decrease) in net assets without donor restrictions	6,464,166	(414,393)	-	6,049,773
Net assets released from restrictions for capital acquisitions	1,929,843	-	-	1,929,843
Increase (decrease) in net assets without donor restrictions	$ 8,394,009	$ (414,393)	$ -	$ 7,979,616

Schedule 2
(Concluded)

WEEKS MEDICAL CENTER AND LANCASTER PATIENT CARE CENTER

Consolidating Statement of Operations

Year Ended September 30, 2020

	Weeks Medical Center	Lancaster Patient Care Center	Eliminations	Total
Revenues, gains and other support without donor restrictions				
Patient service revenue, net	$ 52,106,519	$ -	$ -	$ 52,106,519
Less provision for bad debts	2,110,777	-	-	2,110,777
Net patient service revenue	49,995,742	-	-	49,995,742
Other revenues	6,328,035	179,000	-	6,507,035
HHS stimulus revenue	3,715,618	-	-	3,715,618
Net assets released from restrictions for operations	86,073	-	-	86,073
Total revenues, gains and other support without donor restrictions	60,125,468	179,000	-	60,304,468
Expenses				
Salaries, wages and fringe benefits	33,174,694	-	-	33,174,694
Contract labor	1,529,067	-	-	1,529,067
Supplies and other	17,188,060	64	-	17,188,124
Medicaid enhancement tax	1,898,368	-	-	1,898,368
Management fee	-	49,750	-	49,750
Depreciation	2,005,788	245,149	-	2,250,937
Interest	433,905	135,818	-	569,723
Total expenses	56,229,882	430,781	-	56,660,663
Operating income (loss)	3,895,586	(251,781)	-	3,643,805
Nonoperating gains (losses)				
Income from investments, net	1,284,512	-	-	1,284,512
Gifts without donor restrictions, net	1,961	-	-	1,961
Community benefit and contribution expense	(59,570)	-	-	(59,570)
Recovery of affiliate bad debt	19,760	-	-	19,760
Net nonoperating gains, net	1,246,663	-	-	1,246,663
Excess (deficiency) of revenues, gains, other support, and non-operating gains over expenses and increase (decrease) in net assets without donor restrictions	5,142,249	(251,781)	-	4,890,468
Net assets released from restrictions for capital acquisitions	221,070	-	-	221,070
Increase (decrease) in net assets without donor restrictions	$ 5,363,319	$ (251,781)	$ -	$ 5,111,538

Weeks Medical Center
Board of Trustees and Officers – 2022

Name	Office
Ruby Berryman	Treasurer
Denise Brisson	
Scott Burns	
Charlie Cotton	Secretary
Dennis Couture	Vice Chair
Sarah Desrochers	Ex-Officio
Zeanny Egea	
William Everleth	
Stanley Holz	
Sharon Kopp	
Fran LaDuke	
Edward J. Samson, III	
Keith Young	Chair

Michael Lee	President & CEO
Celeste Pitts	Vice President of Finance
Mark Morgan	Chief Medical Officer
Kemp Schanlaber	Medical Staff President
Tom Mee	NCH CEO

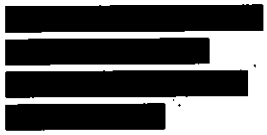
Honorary Members

Rebecca Weeks Sherrill More & Patrick Kelly	Emeritus Trustees

Lisa.Tetreault@northcountryhealth.org
Executive Assistant to the President/CEO & Liaison to Board of Trustees
Corporate Compliance Officer & Risk Management/Legal Affairs
788-5026 – W

Revised: 05.19.22

GLENN B. ADAMS, D.O.
Medical Director/Clinical Coordinator of Physician Services
CURRICULUM VITAE



EMPLOYMENT EXPERIENCE

Weeks Medical Center, 173 Middle Street, Lancaster, New Hampshire. Multi-provider hospital-owned practice. Outpatient clinic located in Groveton, New Hampshire. Full medical and obstetrical admitting privileges to Weeks Medical Center, September 2001 to present.

Laboratory Technician, Washington State University, Pullman, Washington, 1993-1994

High School Science Teacher, Katahdin High School, Sherman Station, Maine, 1990-1991

U.S. Peace Corps Volunteer, High School Science Teacher, Kenya, 1987-1989

HOSPITAL APPOINTMENTS

Medical Director, Weeks Medical Center Physicians' Office Practice

Head of Service for Office Practice, October 2008

Medical Director Hospice of Lancaster, May 2003

Medical Director Weeks Home Health, April 2005

Medical Director Weeks Medical Center Rehabilitation Department, July 2002

EDUCATION

Family Practice Residency Program, Eastern Maine Medical Center, Bangor, Maine, June 2001

Doctor of Osteopathy, University of New England College of Osteopathic Medicine (UNECOM), Biddeford, Maine, June 1998

Master of Science, Chemical Engineering, Washington State University, Pullman, Washington, August 1993

Bachelor of Chemical Engineering, University of Delaware, Newark, Delaware, June 1985

BOARD CERTIFICATION

Board Re-certified in Family Medicine, 2007

HONORS AND AWARDS

CIBA-GEIGY Award for Outstanding Community Service, UNECOM, fall 1996

Sewall Scholarship, UNECOM, for my desire to practice rural primary care medicine

Member of the University of Delaware Honors Program

Paul B. Weisz Award for undergraduate research, University of Delaware, 1985

VOLUNTEER/COMMUNITY SERVICE ACTIVITIES

President, Physicians For Social Responsibility, UNECOM, 1995-1996

Vice President and Class Officer, Student Government Association, UNECOM, 1994-1996

Updated 2/2009

MICHAEL D. LEE, MBA, MLA, SPHR, SHRM-SCP
[redacted]

EXECUTIVE HIGHLIGHTS

Executive Servant Leadership
Physician Recruitment, Contracting & Practice Management
Budget Creation, Financial Analysis & Administration
Payroll Processing, Cost Accounting & Salary Administration
Grievance & Incident Investigation and Resolution
Strategic & Management Action Planning & Coaching
Quality Assurance & Performance Improvement
System & Staffing Analysis & Redesign
Team Building & Exceptional Customer Service
Certified in Labor Relations & Negotiations

EXPERIENCE

Adirondack Medical Center
Chief Human Resources Officer, Interim COO & Administrator, December 2012 – Present
-Developed per diem provider pool to reduce locum utilization
-Contributed to strategic plan creation with specific responsibility in staffing transitions & population health
-Assisted with organizational cost reductions, including programming &staffing analysis, that saved the organization over 2 Million
-Implemented self insured health & prescription drug, short and long term disability, long term care and college savings plans
-Re-opened collective bargaining agreement with UFCW and re-negotiated a three year contract with NYSNA
-Re-organized human resources department and functions to assist with organizational cost reduction and eliminated three FTEs
Vice President of Human Resource, Physician Practices & Rehabilitation & Laboratory Services, March 2007 - August 2008
-Designed in-house physician recruitment & retention, contracted with providers & co-administered five health centers
-Provided leadership and fiscal guidance for operating three laboratories, four outpatient rehab centers & five physician practices
-Negotiated three year contract with New York State Nurses' Association, below budgetary constraints
-Developed a monthly labor management meeting with newly acquired nursing homes
-Developed and administered a consumer driven employee health insurance plan

St. Andrews Hospital and Healthcare: St. Andrews Village
Executive Director & Administrator for the Gregory Wing, Save Havens & Assisted Living, June 2009 – December 2012
-Interim Vice President of Senior Living over two senior living communities & home health and hospice
-Integrated long-term care nursing, billing, facilities and security with LCHC Senior Services
-Co-developed clinical documentation quality control processes & financial turn-around
-Forecasted increased future bed demand needs for nursing facility & completed multi-year pro-formas
-Improved St. Andrews Association customer satisfaction exceeds rating from 25% to 95%
Vice President of Human Resources, March 2006 - March 2007
-Conducted wage and salary review and created salary grids and formalized compensation practices
-Automated human resources reports utilizing Medi-tech and Excel

Sebasticook Family Doctors
Interim Chief Executive Officer, September 2008 - June 2009
-Doubled the medical staff size in ten months and expanded clinic services by adding two additional sites
-Created short term financial strategy turn-around from a 15% loss to a 2.5% positive operating margin
-Renegotiated employee benefits and saved approximately $80 thousand annually
-Drafted and was awarded Increased Demand for Service BPHC grant

Mid-Coast Mental Health Center, March 2001 to March 2006 (Acquired by Penobscot Health)
Director of Human Resources, & Administration March 2001 to March 2006
Interim Executive Director & Chief Financial Officer, June 2005 to March 2006
-Facilitated merger and work teams including Clinical Models, Compliance, Accounting, and Human Resources
-Negotiated thirteen contracts with Maine DOH
-Designed and administered employee satisfaction survey and facilitated action plan that improved satisfaction
-Negotiated employee benefits annually, implemented a PPO & HMO, changed retirement plan broker and TPA

Inland Hospital,
Vice President of Human Resources and Administrative Operations, March 2000 to April 2001
-Completed Human Resources', Facilities, Engineering, Housekeeping & Dietary Services Strategic Plans
-Oversaw the building, financing and operating of a $14 million, co-owned medical office building
-Revised compensation grids, Human Resources' & Administrative Policies and Employee Handbook
-Developed and administered Rabbi Trust for Corporate Executives
-Served as Plan Administrator & Benefits Manager and architect for a self insured HMO and POS plans

Clark Sports Center & Learning Institute
Interim Executive Director, June 1999 to March 2000
Director of Administration: Controller & Director of Human Resources, October 1994 to June 1997
-Provided operational leadership and directly managed Human Resources, Accounting, Human Resources & Facilities
-Developed and Administered operating budgets
-Continued Strategic Planning Process and facilitated program development and customer service training
-Upgraded all hardware to be Y2K compliant & installed accounting & membership software
-Localized accounting functions and automated accounting general ledger and payroll processing
-Created salary classification system, job descriptions, employee handbook and bid and administered benefits

Sun Yacht Charters, Incorporated (Acquired by Star Dust Marine)
Chief Financial & Human Resources Officer, September 1998 to March 1999
-Completed general ledger installation and conversion
-Created and administered international budgets
-Projected cash flow, generated cost analysis, consolidated financial reports & processed payroll
-Designed and managed employee benefits, job descriptions, evaluations and salary grids

Pathfinder Village, Incorporated
Director of Operations, June 1997 to September 1998
-Directed Personnel & Accounting, oversaw School, Programs, Staff Education, Food Service and Facilities
-Created salary grids and updated benefit package, job descriptions and employee handbook
-Revised administrative, program, and residential policies and procedures
-Participated in Comprehensive Agency Reviews and Private Residential School Certification
-Directly managed corporate compliance, risk management & state contract negotiations and administration
Responsible for: 3 Senior Staff; 7 Supervisors and 130 Staff

The Bassett Research Institute
Grants Administration Officer, June 1993 to October 1994
-Drafted budget and administrative portion of grants
-Petitioned sponsoring agencies for funds disbursements
-Created and maintained databases for research studies and grant tracking
-Facilitated project meetings and presented interim statistics

Electronic Data Systems, Financial Analyst and Accountant
Invoice Reconciliation, Dallas, Texas, February 1990 to September 1990
Mexico Operations, Mexico City, Mexico, September 1990 to September 1991
Border Operations, Juarez, Chihuahua Mexico, September 1991 to January 1993

COMPUTER
Excel, Word, Access, Lawson, LAN Administrator, Lotus, Q&A, Gem, Word Perfect, Harvard Graphics, Basic, Visio, and QuickBooks, Peachtree, JD Edwards and McCormick & Dodge General Ledger Packages, ADP and Paychecks payroll processing and software, Report Writer and Preview HRIS, and PsychConsult

EDUCATION
Clarkson University, Potsdam, New York
GPA: 3.7/4.0
MBA, Concentration Finance and Personnel Management, May 1989
Merit Scholarship and Teaching Assistantship in Economics
Vice President of Graduate Management Association

State University of New York, Oneonta, New York
GPA: 3.7/4.0
BA, Business Economics, December 1987
Honors Student
conomics Tutor

ADDITIONAL TRAINING

Multi-level nursing home administrator licensed in NY and ME, certified Senior Professional Human Resources (SPHR), certified in Labor Relations - Collective Bargaining through Cornell University's ILR. Woodstock Institute: Collaborating and Leading in Today's World, Accounting and Finance Development Program (EDS), Human Resources and the Law, Year End Reporting Requirements, LAN Administrator, Grant Preparation (PHS 498), Participated in Center for Creative Leadership Forum, OSHA Certification, Incident Investigation, Rights and Responsibilities of Recipients, Attended Access, Internet, PC Troubleshooting Training, Healthcare Systems in the United States and sundry other seminars.

COMMUNITY SERVICE

Volunteered with Island Institute and previously with the SPCA, and Children's Triathlon Club, Ran the Boston Marathon for Dana Farber Cancer Research, and assisted in grant writing and preparation for community health and education endeavors. Prior Supervisory Committee Chair of Bassett Federal Credit Union & Treasurer of LEAF.

REFERENCES

Judy McGuire, MBA
Sr. Vice President Home Health and Sr. Services
MaineHealth Board Member
[redacted]

Wendy Roberts, MPH
Executive Director, St. Andrews Village
[redacted]

Margaret Pinkham, MBA
Prior: President and CEO of St. Andrews Healthcare
[redacted]

Dan Bennett, MBA
Prior: Executive Director Mid-Coast Mental Health
[redacted]

Linda S. Dening, MBA
Assistant Professor of Accounting
Jefferson Community College
[redacted]

Celeste K. Pitts
Weeks Medical Center
[redacted]

EXPERIENCE

CFO — **July 2009 - Present**
Weeks Medical Center — **Lancaster, NH**

Same responsibilities as Controller position, with added responsibility for Patient Accounting Department and Senior management duties.

Controller — **Jan. 2007 – July 2009**
Weeks Medical Center — **Lancaster, NH**

Responsible for all general accounting functions, including monthly closings and annual audit. Monthly reporting to Board of Directors Finance Committee. Responsible for preparation of Medicare Cost Report, and working with auditors from NGS. Annual budget preparation, 5 year plan preparation and annual chargemaster price increase. Work closely with other managers on chargemaster maintenance, budgeting and have developed an internal dashboard that is currently being used by all managers for quarterly budget meetings. Supervise Accounts Payable & Payroll functions and Financial Analyst position.

Senior Accountant/Financial Analyst — **Jan. 2006 – Dec. 2006**
Weeks Medical Center — **Lancaster, NH**

Responsible for Financial Statement preparation and analysis using the McKesson Paragon Software System. Reporting to various agencies, such as New Hampshire Data Bank. Miscellaneous financial reporting as needed for Dartmouth-Hitchcock Alliance. Worked closely with the CFO to prepare the Medicare Cost Report. Assisted with the budgeting process for the hospital. Responsible for all Bank Reconciliations and other account reconciliations, in particular the endowment and investment funds.

Business Manager — **Feb. 2005-Jan. 2006**
Morrison Nursing Home — **Whitefield, NH**

Responsible for all Accounting functions, in particular Financial Statement preparation and analysis. General Ledger Account Reconciliations, preparation of audit workpapers, Bank Reconciliations and Resident Trust Reconciliation. Responsible for all billing functions, including Medicare and Medicaid. Supervised Human Resources, Accounts Payable personnel and Receptionist. Worked directly with Administrator to report to the Board. Established correct billing procedures for Medicare Consolidated Billing for Skilled Nursing Facilities to include proper charges and cleaned up the outstanding Accounts Receivable from about 90 days to 30 days.

EXPERIENCE (Continued)

Bookkeeper — **July 2001-February 2005**
Cherry Pond Designs — **Jefferson, NH**

Responsible for all Payroll, Accounts Payable & Receivable and Invoicing functions using QuickBooks. This was a part-time position.

Bookkeeper/Accountant — **Dec. 1993 – July 1996**
Fairfield Mall Management Office — **Chicopee, Mass.**

Responsible for all Accounts Receivable and Payable functions using the J.D. Edwards computer accounting system. Prepared audit work papers for outside auditors. Brought monthly sales report on-line and was used as the test case for all the properties. Compiled annual budget, which consisted of a Microsoft Excel file, composed of over 150 linked worksheets. This was a part time position. Periodically responsible for all accounting functions, which included all of the above plus general journal entries and monthly financial statement preparation.

Controller — **Aug. 1982–June 1984**
Hendrix Wire and Cable — **Milford, NH**

Responsible for preparation and analysis of monthly financial statements, preparing schedules and assisting outside auditors on year-end audit, compilation of yearly budgets and supervision of Accounts Receivable and Payables, General Ledger and Payroll functions. Managed a staff of five employees. Responsible for all data processing functions, which included installation of computer applications, supervision of data conversion and training of personnel.

Assistant Controller — **Sept. 1980–Aug. 1982**
Hendrix Wire and Cable — **Milford, NH**

Prepared monthly financial statements for Controller to analyze. Maintained FIFO records and costed monthly inventories. Maintained fixed asset records. IBM System/34 Operator. Responsible for installing application software, software maintenance and security.

EDUCATION

New Hampshire College — **May 1985**
Masters in Business Administration

Bentley College — **May 1980**
Bachelor of Science in Accounting

Karen A. Woods RT (R)(M)(CT)

→ *Well-rounded healthcare executive seeking meaningful opportunity.*

→ *Versed in both critical access hospital and rural health clinic operations.*

→ *Prides self in building professional relationships that enhance staff satisfaction, promote quality patient care, and secure excellent outcomes.*

→ *Life-long north country resident.*

Prepared December 11, 2021

Education

Ottawa University — Online
Masters in Leadership — 2019 -present

Ottawa University — Online
Bachelors in Healthcare Management — 2015-2017

New Hampshire Technical Institute
Concord, NH
Associates in Science / Radiographic Technology — 1990-1992

Certifications / Licensures

ARRT: — 1992-present
- Radiography
- Computed Tomography
- Mammography

New Hampshire Imaging Board — 2019-present

Professional Organizations

American Society of Radiologic Technologist — 2002-present

Professional Collaborations

North Country Health Consortium
- Board Member — 2016-present

NH IDN
- Steering Committee — 2016-2020

Haverhill Area Substance Misuse Prevention Coalition
- Chairperson — 2015-present

Youth Restorative Justice — 2019-present
- Panel Member

Memberships

American Society of Radiologic Technologists (ASRT) — 2005-present

Professional Highlights / Awards

ASRT Imaging Professionals of the Year — 2006

N.H. Business Review's: Business Excellence Award for Large Healthcare Facility — 2020

Work History

Administrative Director — 2015 - present

Cottage Hospital
Woodville, NH

- Member of executive team.
- Provide administrative operational oversight and budgetary governance for several departments to include: Diagnostic Imaging, Physical and Occupational Therapy, Laboratory, Specialty Clinics: Orthopedics, Dermatology, Cardiology, Mental Health, Pain Management, Endocrinology, Gastroenterology, General Surgery, and Podiatry, Primary Care in an RHC setting, Facilities Management, Life Safety, and Environmental Services.
- Mentor Department Directors of above outlined specialties in operations, financial processes, regulatory needs, and human resource management.
- Monitor CMS readiness for above departments.
- Review, analyze, and interpret profit and loss statements; investigate fiscal incongruities.
- Monitor quality measures, outcomes, and performance improvements.
- Serve as strategic advisor on operational matters, align department strategies to organization's strategic plan.
- Work with medical directors of departments to ensure enhanced patient experience and promote best practice.
- Monitor business plan effectiveness.
- Create, monitor, and maintain budgets for several departments.
- Lead Department Directors to develop high-performing teams that collaborate towards organization's goals.
- Organize and direct several capital improvement projects across organization.
- Project lead on:
    - EMR transition
    - Construction of Medical Art Building: 8,000 sq. foot RHC
    - Renovation of inpatient unit
    - Website design
    - ACO
- Ongoing Planning Section Chief for pandemic Incident Command.
- Wrote and secured a USDA grant.
- Completed a certificate of need for renovation project.
- Created Emergency Preparedness Plan for RHC.
- Lead Community Benefit Reporting and Community Needs Assessment.

Director of Radiology / PACS Administrator — 2008-2015

Cottage Hospital
Woodsville, NH

- Continued Chief Mammographer responsibilities.
- Continued PACS Administrator responsibilities.
- Created staffing schedules.
- Maintained CMS survey readiness.
- Developed policies and procedures to ensure compliance with federal, state, and local law and regulations.
- Ensured safe use of equipment by staff; ensured radiation safety.
- Maintained dosimetry program.
- Hire and counsel staff.
- Monitored profit and loss across modalities.
- Completed regular quality control measures for equipment across department.
- Scheduled equipment for preventative maintenance, services, and physicist inspections.
- Created business initiatives to increase program utilization.
- Created operational budgets for each modality.
- Identified and led capital project needs of each modality.
- Acted as liaison between community providers and radiology services.
- Maintained department documents for staff and equipment.

Assistant Manager of Radiology / Chief Mammographer **2006-2008**
Cottage Hospital
Woodsville, NH

- Continued staff technologist and associated duties.
- Continued PACS Administrator and associated duties.
- Mammography Charge responsible for:
  - Policies and procedure
  - QC
  - ACR inspections
  - MQSA inspections
- Assistant Manager responsible for:
  - Staff scheduling
  - Department safety
  - Equipment PM schedules
  - Staff competencies
  - Back up to Director

PACS Administrator **2005-2015**
Cottage Hospital
Woodsville, NH

- Continued staff technologist and associated duties.
- Project lead on PACS implementation for facility.
- Ensured optimal operation of archiving system, system monitoring and maintenance.
- Investigate and address any image issues.
- Trained staff and providers on use of system.
- Liaison with area providers to install access to PACS from offices.

Staff Technologist **2002-2005**
Cottage Hospital
Woodsville, NH

- Performed quality imaging.
- Practiced radiation safety.
- Maintained competency in radiography, computed technology, and mammography.
- Promoted exceptional patient experiences / focused on high patient satisfaction.
- Mentored radiology students.

CONTRACTOR NAME

Key Personnel

Name	Job Title	Annual Salary	Salary Amount Paid from this Contract
Michael Lee	President & CEO	$279,999	$0
Celeste Pitts	Vice President of Financial Services	$180,406	$0
Karen Woods	VP of Provider Practices	$156,000	$4,680
Glenn Adams, DO	Office Head of Service	$283,659	$0

Subject: Maternal and Child Health Care in the Integrated Primary Care Setting (RFP-2022-DPHS-19-PRIMA-10)

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name White Mountain Community Health Center		1.4 Contractor Address 298 White Mountain Highway Conway, NH 03818	
1.5 Contractor Phone Number (603) 447-8900	1.6 Account Number 05-95-90-90210-5190	1.7 Completion Date June 30, 2024	1.8 Price Limitation $624,885
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature DocuSigned by: 78F8... Date: 5/18/2022		1.12 Name and Title of Contractor Signatory Kenneth Porter ED	
1.13 State Agency Signature DocuSigned by: Iain Watt D7788B63F9704C7... Date: 5/25/2022		1.14 Name and Title of State Agency Signatory Iain Watt Deputy Director - DPHS	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Takhmina Rakhmatova FDF521C025C24AC... On: 5/31/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials DS KRP
Date 5/18/2022

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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Date 5/18/2022

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omissions of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

Contractor Initials DS KAP

Date 5/18/2022

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Effective Date/Completion of Services, is amended by adding subparagraph 3.3 as follows:

3.3. The parties may extend the Agreement for up four (4) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

1.2. Paragraph 12, Assignment/Delegation/Subcontracts, is amended by adding subparagraph 12.3 as follows:

12.3. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions. The Contractor shall have written agreements with all subcontractors, specifying the work to be performed, and if applicable, a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act. Written agreements shall specify how corrective action shall be managed. The Contractor shall manage the subcontractor's performance on an ongoing basis and take corrective action as necessary. The Contractor shall annually provide the State with a list of all subcontractors provided for under this Agreement and notify the State of any inadequate subcontractor performance.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall increase access to integrated healthcare for the Maternal and Child Health (MCH) target population of Women, Infants, Children and Adolescents from birth to 21 years of age, and to address the Maternal, Children and Youth health priorities as identified in the State's Maternal and Child Health five (5) year Statewide Needs Assessment completed in 2020.

1.2. The Contractor shall provide and increase access to healthcare for New Hampshire Infants, Children and Adolescents from birth to 21 years of age, and Pregnant Women and Women of Childbearing age, and must not exclude individuals who are:

1.2.1. Uninsured.

1.2.2. Underinsured.

1.2.3. Considered low-income defined as less than 185% of the U.S. Department of Health and Human Services (US DHHS) Poverty Guidelines.

1.2.4. Lacking housing, including individuals whose primary residence during the night is a supervised public or private facility, such as a shelter, that provides temporary living accommodations.

1.2.5. Residing in transitional housing.

1.2.6. Unable to maintain their housing situation.

1.2.7. Forced to stay with a series of friends and/or extended family members, hence are considered homeless.

1.2.8. Recently released from a prison or a hospital and do not have a stable housing situation to which they can return, especially if they were considered to be homeless prior to incarceration or hospitalization.

1.3. The Contractor shall provide integrated preventative and primary health care services to the populations in Subsection 1.2 above, which must include:

1.3.1. Behavioral health care;

1.3.2. Prenatal care either on site or by referral;

1.3.3. Care management; and

1.3.4. Enabling services.

1.4. The Contractor shall provide eligibility determination services that include, but are not limited to:

1.4.1. Notifying the Department in writing if/when access to primary care services for new patients is limited or closed for more than thirty (30)

consecutive business days or any sixty (60) non-consecutive business days.

1.4.2. Assisting individuals with completing a Medicaid/Expanded Medicaid and/or other health insurance applications.

1.4.3. Maximizing billing to private and commercial insurances for all reimbursable services rendered.

1.4.4. Posting a public notice in a conspicuous location specifying that no individual will be denied services due to inability to pay.

1.4.5. Developing and implementing a sliding fee scale for services in accordance with the Federal Poverty Guidelines and providing the sliding fee scale to the Department upon request.

1.5. The Contractor shall ensure primary care services are provided by a New Hampshire licensed:

1.5.1. Medical Doctor (MD);

1.5.2. Doctor of Osteopathic Medicine (DO);

1.5.3. Advanced Practice Registered Nurse (APRN); and/or

1.5.4. Physician Assistant (PA) to eligible individuals in the service area.

1.6. The Contractor shall provide services in an office-based setting which may include, but is not limited to:

1.6.1. Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics.

1.6.2. School Based Health Clinics.

1.6.3. Mobile Care Delivery Services.

1.7. The Contractor shall ensure services include, but are not limited to:

1.7.1. Reproductive health services.

1.7.2. Perinatal health services including, but not limited to, access to obstetrical services either on-site or by referral.

1.7.3. Preventive primary care services for women, infants, children and adolescents, including screenings and health education in accordance with established, documented state or national guidelines and evidence based practices.

1.7.4. Integrated behavioral health services.

1.7.5. Assessment of need and follow-up/referral as indicated for:

1.7.5.1. Tobacco cessation, including referral to programs such as QuitWorks-NH (http://www.QuitWorksNH.org);

1.7.5.2. Social services that address Social Determinants of Health (SDOH);

1.7.5.3. Chronic Disease management, including disease specific referral and self-management education such as referral to Diabetes Self-Management Education (DSME) as recommended by American Diabetes Association (ADA);

1.7.5.4. Nutrition services, including Women, Infants and Children (WIC) Food and Nutrition Service, as appropriate;

1.7.5.5. Screening, Brief Intervention and Referral to Treatment (SBIRT) services; and

1.7.5.6. Referrals to any specialists as needed that are not offered on site, including home visiting services and oral health.

1.8. The Contractor shall provide and facilitate enabling services to all individuals served with special emphasis given to the MCH population of women and infants, children and adolescents from birth to 21 years of age. Enabling services must include at a minimum:

1.8.1. Case management;

1.8.2. Benefit counseling and/or eligibility assistance;

1.8.3. Health education and supportive counseling; and

1.8.4. Language interpretation, outreach, transportation and education of patients and the community regarding the availability and appropriate use of health services.

1.9. The Contractor shall ensure management services for individuals enrolled for primary care services include, but are not limited to:

1.9.1. Integrated and coordinated services that ensure patients receive necessary care, including behavioral health and oral care when and where it is needed and wanted, and in a culturally and linguistically appropriate manner; and

1.9.2. Direct access to a healthcare provider by telephone twenty-four (24) hours per day, seven (7) days per week, by referral or subcontract.

1.10. The Contractor shall develop, define, facilitate and implement a minimum of two (2) enabling services initiatives and enabling services initiative work plans that focus on the Title V MCH Block Grant population of women, infants, children and adolescents, as follows:

1.10.1. Initiative One (1) – Screening and Referrals for SDOH, in accordance with Attachment #1; and

1.10.2. Initiative Two (2) – Home Visiting Referrals, in accordance with Attachment #2.

1.11. The Contractor shall monitor, update and implement each enabling services initiative work plan in accordance with Attachment #3 – Reporting Requirements Calendar.

1.12. The Contractor shall develop, define, facilitate and implement a minimum of two (2) quality improvement (QI) projects, which must consist of systematic and continuous actions that lead to measurable improvements in health care services and the health status of all individuals served, including:

1.12.1. QI Project One (1): Adolescent Well-Care Visits, in accordance with Attachment #4; and

1.12.2. QI Project Two (2): Depression Screening, in accordance with Attachment #5.

1.13. The Contractor shall monitor, update and implement the work plans for each QI project in accordance with Attachment #3 – Reporting Requirements Calendar.

1.14. The Contractor shall attend in-person and/or virtual meetings and trainings facilitated by the Department, which include, but are not limited to:

1.14.1. MCH Agency Directors' Meetings scheduled by the Department on an as-needed basis.

1.14.2. MCH Primary Care Coordinators' Meetings up to two (2) times per year, which may require attendance by selected Vendor(s) quality improvement and clinical staff.

1.15. The Contractor shall ensure all services in this Exhibit B, Scope of Services, are provided by qualified health and allied health professionals.

1.16. The Contractor shall provide supporting documentation to the Department that verifies staff hours funded under the Agreement that may include, but is not limited to, timecards.

1.17. The Contractor shall ensure all health and allied health professionals possess and maintain the appropriate and current New Hampshire licenses whether directly employed, contracted or subcontracted.

1.18. The Contractor shall notify the Department in writing of any newly hired administrator, clinical coordinator or staff person essential to providing services. The Contractor shall ensure notification:

1.18.1. Is provided to the Department no later than thirty business (30) days from the date of hire; and

1.18.2. Includes a copy of the newly hired individual's resume.

1.19. The Contractor shall notify the Department in writing when:

1.19.1. Any critical position is vacant for more than thirty (30) business days;

1.19.2. There is not adequate staffing to perform all required services for any period lasting more than thirty (30) consecutive business days or any sixty (60) non-consecutive business days.

1.20. The Contractor shall ensure that all employees and subcontractors providing direct services to clients under this Agreement have undergone a criminal background check and have no convictions for crimes that represent evidence of behavior that could endanger clients served under this Agreement.

1.21. The Contractor shall permit an individual, or team or individuals, authorized by the Department to schedule and conduct periodic virtual and/or on-site reviews of documentation related to contracted services, including:

1.21.1. Administration;

1.21.2. Data collection and submission;

1.21.3. Clinical and financial management; and

1.21.4. Delivery of education services.

1.22. The Contractor shall ensure the information needed by the Department to conduct virtual and/or on-site reviews is available, which may include, but is not limited to:

1.22.1. Client records.

1.22.2. Documentation of approved enabling services and quality improvement projects, including process and outcome evaluations.

1.23. The Contractor shall adhere to any corrective action plans issued by the Department should virtual and/or on-site reviews yield results that services provided are not in compliance with the Agreement. Any corrective action plans shall not prevent the Department from taking action under paragraph 8, Event of Default/Remedies and paragraph 9, Termination, of the General Provisions, Form P-37, of the Agreement.

1.24. The Contractor shall actively and regularly collaborate with the Department to enhance contract management and improve results.

1.25. The Contractor may be required to collect and share other key data and metrics with the Department, including client-level demographic, performance, and service data, in a format specified by the Department.

1.26. Reporting

1.26.1. The Contractor shall collect and submit the data and reports as specified in Attachment #3 – Reporting Requirements Calendar to the Department. Data must be de-identified and aggregated to prevent constructive identification of any individual, and must include but is not limited to:

1.26.1.1. Uniform Data System (UDS) outcomes.

1.26.1.2. Performance Measure outcomes.

1.26.1.3. Work plan for each Enabling Service Initiative.

1.26.1.4. Work Plan for each QI Project.

1.27. Performance Measures

1.27.1. The Contractor shall report data on the Performance Measures in Appendix F at regular intervals as specified in Appendix G – Reporting Requirements Calendar, utilizing Appendix K – DTT-PC2022 Template.

1.27.2. The Contractor shall meet or exceed their proposed goals and objectives for the required Performance Measures in Attachment #6. Should the Contractor not meet or exceed their goals, the Contractor shall submit a Performance Measure Improvement Plan for each unmet Performance Measure, utilizing Attachment #7 – Performance Measure Outcome Report Template, at reporting intervals as specified in Appendix G – Reporting Requirements Calendar.

1.27.3. The Department may identify other performance measures in the resulting Agreement.

2. Exhibits Incorporated

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and in accordance with the attached Exhibit I, Business Associate Agreement, which has been executed by the parties.

2.2. The Contractor shall manage all confidential data related to this Agreement in accordance with the terms of Exhibit K, DHHS Information Security Requirements.

2.3. The Contractor shall comply with all Exhibits D through K, which are attached hereto and incorporated by reference herein.

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

3.1.1. The Contractor agrees that, to the extent future state or federal legislation or court orders may have an impact on the Services described herein, the State has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

3.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

3.2.1. The Contractor shall submit, within ten (10) days of the Agreement Effective Date, a detailed description of the communication access and language assistance services to be provided to ensure meaningful access to programs and/or services to individuals with limited English proficiency; individuals who are deaf or have hearing loss; individuals who are blind or have low vision; and individuals who have speech challenges.

3.3. Credits and Copyright Ownership

3.3.1. All documents, notices, press releases, research reports and other materials prepared during or resulting from the performance of the services of the Agreement shall include the following statement, "The preparation of this (report, document etc.) was financed under an Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services."

3.3.2. All materials produced or purchased under the Agreement shall have prior approval from the Department before printing, production, distribution or use.

3.3.3. The Department shall retain copyright ownership for any and all original materials produced, including, but not limited to:

3.3.3.1. Brochures.

3.3.3.2. Resource directories.

3.3.3.3. Protocols or guidelines.

3.3.3.4. Posters.

3.3.3.5. Reports.

3.3.4. The Contractor shall not reproduce any materials produced under the Agreement without prior written approval from the Department.

3.4. Operation of Facilities: Compliance with Laws and Regulations

3.4.1. In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental

license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Agreement the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

4. Records

4.1. The Contractor shall keep records that include, but are not limited to:

4.1.1. Books, records, documents and other electronic or physical data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor.

4.1.2. All records must be maintained in accordance with accounting procedures and practices, which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.

4.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.

4.1.4. Medical records on each patient/recipient of services.

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided

however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

New Hampshire Department of Health and Human Services
Maternal and Child Health Care in the Integrated Primary Care Setting
EXHIBIT C

Payment Terms

1. This Agreement is funded by:
   1.1. 10% Federal funds from the Maternal and Child Health Services Block Grant to the States, as awarded on October 19, 2021, by the U.S. Department of Health and Human Services, Health Resources and Services Administration, CFDA #93.994, FAIN B04MC45230.
   1.2. 90% General funds.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Subrecipient, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line items, as specified in Exhibit C-1, Budget through Exhibit C-3, Budget.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to DPHSContractBilling@dhhs.nh.gov or mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.

6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

7. Notwithstanding Paragraph 17 of the General Provisions Form P-37, changes limited to adjusting amounts within the price limitation and adjusting encumbrances between State Fiscal Years and budget class lines through the Budget Office may be made by written agreement of both parties, without obtaining approval of the Governor and Executive Council, if needed and justified.

8. Audits

8.1. The Contractor must email an annual audit to dhhs.act@dhhs.nh.gov if any of the following conditions exist:

8.1.1. Condition A - The Contractor expended $750,000 or more in federal funds received as a subrecipient pursuant to 2 CFR Part 200, during the most recently completed fiscal year.

8.1.2. Condition B - The Contractor is subject to audit pursuant to the requirements of NH RSA 7:28, III-b, pertaining to charitable organizations receiving support of $1,000,000 or more.

8.1.3. Condition C - The Contractor is a public company and required by Security and Exchange Commission (SEC) regulations to submit an annual financial audit.

8.2. If Condition A exists, the Contractor shall submit an annual Single Audit performed by an independent Certified Public Accountant (CPA) to dhhs.act@dhhs.nh.gov within 120 days after the close of the Contractor's fiscal year, conducted in accordance with the requirements of 2 CFR Part 200, Subpart F of the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal awards.

8.2.1. The Contractor shall submit a copy of any Single Audit findings and any associated corrective action plans. The Contractor shall submit quarterly progress reports on the status of implementation of the corrective action plan.

8.3. If Condition B or Condition C exists, the Contractor shall submit an annual financial audit performed by an independent CPA within 120 days after the close of the Contractor's fiscal year.

8.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *White Mountain CHC*

Budget Request for: *MCH PC*

Budget Period *date of G&C approval – 6/30/22*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$20,736
2. Fringe Benefits	$1,993
3. Consultants	$300
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	
5.(d) Supplies - Medical	
5.(e) Supplies Office	$0
6. Travel	
7. Software	
8. (a) Other - Marketing/Communications	
8. (b) Other - Education and Training	
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$1,966
Total Direct Costs	$24,995
Total Indirect Costs	$0
TOTAL	**$24,995**

Contractor Initials DS KGP

Date 5/18/2022

New Hampshire Department of Health and Human Services *Complete one budget form for each budget period.* **Contractor Name:** *White Mountain CHC* **Budget Request for:** *MCH PC* **Budget Period** *July1,2022-June 30, 2023* **Indirect Cost Rate (if applicable)** 0.00%	
Line Item	**Program Cost - Funded by DHHS**
1. Salary & Wages	$224,952
2. Fringe Benefits	$27,046
3. Consultants	$5,800
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$867
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$1,000
5.(e) Supplies Office	FY
6. Travel	$500
7. Software	$9,000
8. (a) Other - Marketing/Communications	$2,100
8. (b) Other - Education and Training	$3,000
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$25,680
Total Direct Costs	$299,945
Total Indirect Costs	$0
TOTAL	**$299,945**

DS
Contractor Initials

5/18/2022
Date

New Hampshire Department of Health and Human Services

Complete one budget form for each budget period.

Contractor Name: *White Mountain CHC*

Budget Request for: *MCH PC*

Budget Period *July 1, 2023- June 30, 2024*

Indirect Cost Rate (if applicable) 0.00%

Line Item	Program Cost - Funded by DHHS
1. Salary & Wages	$224,952
2. Fringe Benefits	$27,046
3. Consultants	$5,800
4. Equipment *Indirect cost rate cannot be applied to equipment costs per 2 CFR 200.1 and Appendix IV to 2 CFR 200.*	$0
5.(a) Supplies - Educational	$867
5.(b) Supplies - Lab	$0
5.(c) Supplies - Pharmacy	$0
5.(d) Supplies - Medical	$1,000
5.(e) Supplies Office	$0
6. Travel	$500
7. Software	$9,000
8. (a) Other - Marketing/Communications	$2,100
8. (b) Other - Education and Training	$3,000
8. (c) Other - Other (specify below)	
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
Other (please specify)	$0
9. Subrecipient Contracts	$25,680
Total Direct Costs	$299,945
Total Indirect Costs	$0
TOTAL	**$299,945**

Contractor Initials DS KSP

Date 5/18/2022

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

This certification is required by the regulations implementing Sections 5151-5160 of the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subtitle D; 41 U.S.C. 701 et seq.). The January 31, 1989 regulations were amended and published as Part II of the May 25, 1990 Federal Register (pages 21681-21691), and require certification by grantees (and by inference, sub-grantees and sub-contractors), prior to award, that they will maintain a drug-free workplace. Section 3017.630(c) of the regulation provides that a grantee (and by inference, sub-grantees and sub-contractors) that is a State may elect to make one certification to the Department in each federal fiscal year in lieu of certificates for each grant during the federal fiscal year covered by the certification. The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment. Contractors using this form should send it to:

Commissioner
NH Department of Health and Human Services
129 Pleasant Street,
Concord, NH 03301-6505

1. The grantee certifies that it will or will continue to provide a drug-free workplace by:
   - 1.1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
   - 1.2. Establishing an ongoing drug-free awareness program to inform employees about
     - 1.2.1. The dangers of drug abuse in the workplace;
     - 1.2.2. The grantee's policy of maintaining a drug-free workplace;
     - 1.2.3. Any available drug counseling, rehabilitation, and employee assistance programs; and
     - 1.2.4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   - 1.3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
   - 1.4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will
     - 1.4.1. Abide by the terms of the statement; and
     - 1.4.2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   - 1.5. Notifying the agency in writing, within ten calendar days after receiving notice under subparagraph 1.4.2 from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer on whose grant activity the convicted employee was working, unless the Federal agency

DS KRP

Vendor Initials _____
Date 5/18/2022

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted

1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

Check ☐ if there are workplaces on file that are not identified here.

Vendor Name:

5/18/2022
Date

DocuSigned by:
70F940025535405...
Name: Kenneth Porter
Title: ED

CERTIFICATION REGARDING LOBBYING

The Vendor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Section 319 of Public Law 101-121, Government wide Guidance for New Restrictions on Lobbying, and 31 U.S.C. 1352, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

US DEPARTMENT OF HEALTH AND HUMAN SERVICES - CONTRACTORS
US DEPARTMENT OF EDUCATION - CONTRACTORS
US DEPARTMENT OF AGRICULTURE - CONTRACTORS

Programs (indicate applicable program covered):
*Temporary Assistance to Needy Families under Title IV-A
*Child Support Enforcement Program under Title IV-D
*Social Services Block Grant Program under Title XX
*Medicaid Program under Title XIX
*Community Services Block Grant under Title VI
*Child Care Development Block Grant under Title IV

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor).

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement (and by specific mention sub-grantee or sub-contractor), the undersigned shall complete and submit Standard Form LLL, (Disclosure Form to Report Lobbying, in accordance with its instructions, attached and identified as Standard Exhibit E-I.)

3. The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Vendor Name:

DocuSigned by:

5/18/2022
Date

Name: Kenneth Porter
Title: ED

DS
KGP
Vendor Initials

5/18/2022
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

Contractor Initials DS KAP

Date 5/18/2022

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (I)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

DocuSigned by:

5/18/2022
Date

78F94862F53342E...
Name: Kenneth Porter
Title: ED

DS
KSP
Contractor Initials

5/18/2022
Date

CERTIFICATION OF COMPLIANCE WITH REQUIREMENTS PERTAINING TO FEDERAL NONDISCRIMINATION, EQUAL TREATMENT OF FAITH-BASED ORGANIZATIONS AND WHISTLEBLOWER PROTECTIONS

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

Contractor will comply, and will require any subgrantees or subcontractors to comply, with any applicable federal nondiscrimination requirements, which may include:

- the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. Section 3789d) which prohibits recipients of federal funding under this statute from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act requires certain recipients to produce an Equal Employment Opportunity Plan;

- the Juvenile Justice Delinquency Prevention Act of 2002 (42 U.S.C. Section 5672(b)) which adopts by reference, the civil rights obligations of the Safe Streets Act. Recipients of federal funding under this statute are prohibited from discriminating, either in employment practices or in the delivery of services or benefits, on the basis of race, color, religion, national origin, and sex. The Act includes Equal Employment Opportunity Plan requirements;

- the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, which prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in any program or activity);

- the Rehabilitation Act of 1973 (29 U.S.C. Section 794), which prohibits recipients of Federal financial assistance from discriminating on the basis of disability, in regard to employment and the delivery of services or benefits, in any program or activity;

- the Americans with Disabilities Act of 1990 (42 U.S.C. Sections 12131-34), which prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation;

- the Education Amendments of 1972 (20 U.S.C. Sections 1681, 1683, 1685-86), which prohibits discrimination on the basis of sex in federally assisted education programs;

- the Age Discrimination Act of 1975 (42 U.S.C. Sections 6106-07), which prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. It does not include employment discrimination;

- 28 C.F.R. pt. 31 (U.S. Department of Justice Regulations – OJJDP Grant Programs); 28 C.F.R. pt. 42 (U.S. Department of Justice Regulations – Nondiscrimination; Equal Employment Opportunity; Policies and Procedures); Executive Order No. 13279 (equal protection of the laws for faith-based and community organizations); Executive Order No. 13559, which provide fundamental principles and policy-making criteria for partnerships with faith-based and neighborhood organizations;

- 28 C.F.R. pt. 38 (U.S. Department of Justice Regulations – Equal Treatment for Faith-Based Organizations); and Whistleblower protections 41 U.S.C. §4712 and The National Defense Authorization Act (NDAA) for Fiscal Year 2013 (Pub. L. 112-239, enacted January 2, 2013) the Pilot Program for Enhancement of Contract Employee Whistleblower Protections, which protects employees against reprisal for certain whistle blowing activities in connection with federal grants and contracts.

The certificate set out below is a material representation of fact upon which reliance is placed when the agency awards the grant. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants, or government wide suspension or debarment.

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

The Contractor identified in Section 1.3 of the General Provisions agrees by signature of the Contractor's representative as identified in Sections 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

DocuSigned by:

5/18/2022
Date

Name: Kenneth Porter
Title: ED

New Hampshire Department of Health and Human Services
Exhibit H

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

The Contractor identified in Section 1.3 of the General Provisions agrees, by signature of the Contractor's representative as identified in Section 1.11 and 1.12 of the General Provisions, to execute the following certification:

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

DocuSigned by:

5/18/2022
Date

Name: Kenneth Porter
Title: ED

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 applicable to business associates. As defined herein, "Business Associate" shall mean the Contractor and subcontractors and agents of the Contractor that receive, use or have access to protected health information under this Agreement and "Covered Entity" shall mean the State of New Hampshire, Department of Health and Human Services.

(1) Definitions.

a. "Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

b. "Business Associate" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

c. "Covered Entity" has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations.

d. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 CFR Section 164.501.

e. "Data Aggregation" shall have the same meaning as the term "data aggregation" in 45 CFR Section 164.501.

f. "Health Care Operations" shall have the same meaning as the term "health care operations" in 45 CFR Section 164.501.

g. "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, TitleXIII, Subtitle D, Part 1 & 2 of the American Recovery and Reinvestment Act of 2009.

h. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160, 162 and 164 and amendments thereto.

i. "Individual" shall have the same meaning as the term "individual" in 45 CFR Section 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR Section 164.501(g).

j. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

k. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

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Date 5/18/2022

l. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR Section 164.103.

m. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

n. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 164, Subpart C, and amendments thereto.

o. "Unsecured Protected Health Information" means protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

p. Other Definitions - All terms not otherwise defined herein shall have the meaning established under 45 C.F.R. Parts 160, 162 and 164, as amended from time to time, and the HITECH
Act.

(2) **Business Associate Use and Disclosure of Protected Health Information.**

a. Business Associate shall not use, disclose, maintain or transmit Protected Health Information (PHI) except as reasonably necessary to provide the services outlined under Exhibit A of the Agreement. Further, Business Associate, including but not limited to all its directors, officers, employees and agents, shall not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

b. Business Associate may use or disclose PHI:
   I. For the proper management and administration of the Business Associate;
   II. As required by law, pursuant to the terms set forth in paragraph d. below; or
   III. For data aggregation purposes for the health care operations of Covered Entity.

c. To the extent Business Associate is permitted under the Agreement to disclose PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (i) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (ii) an agreement from such third party to notify Business Associate, in accordance with the HIPAA Privacy, Security, and Breach Notification Rules of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

d. The Business Associate shall not, unless such disclosure is reasonably necessary to provide services under Exhibit A of the Agreement, disclose any PHI in response to a request for disclosure on the basis that it is required by law, without first notifying Covered Entity so that Covered Entity has an opportunity to object to the disclosure and to seek appropriate relief. If Covered Entity objects to such disclosure, the Business

Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

e. If the Covered Entity notifies the Business Associate that Covered Entity has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Business Associate shall be bound by such additional restrictions and shall not disclose PHI in violation of such additional restrictions and shall abide by any additional security safeguards.

(3) **Obligations and Activities of Business Associate.**

a. The Business Associate shall notify the Covered Entity's Privacy Officer immediately after the Business Associate becomes aware of any use or disclosure of protected health information not provided for by the Agreement including breaches of unsecured protected health information and/or any security incident that may have an impact on the protected health information of the Covered Entity.

b. The Business Associate shall immediately perform a risk assessment when it becomes aware of any of the above situations. The risk assessment shall include, but not be limited to:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed
- The extent to which the risk to the protected health information has been mitigated.

The Business Associate shall complete the risk assessment within 48 hours of the breach and immediately report the findings of the risk assessment in writing to the Covered Entity.

c. The Business Associate shall comply with all sections of the Privacy, Security, and Breach Notification Rule.

d. Business Associate shall make available all of its internal policies and procedures, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of Covered Entity to the Secretary for purposes of determining Covered Entity's compliance with HIPAA and the Privacy and Security Rule.

e. Business Associate shall require all of its business associates that receive, use or have access to PHI under the Agreement, to agree in writing to adhere to the same restrictions and conditions on the use and disclosure of PHI contained herein, including the duty to return or destroy the PHI as provided under Section 3 (l). The Covered Entity shall be considered a direct third party beneficiary of the Contractor's business associate agreements with Contractor's intended business associates, who will be receiving PHI

pursuant to this Agreement, with rights of enforcement and indemnification from such business associates who shall be governed by standard Paragraph #13 of the standard contract provisions (P-37) of this Agreement for the purpose of use and disclosure of protected health information.

f. Within five (5) business days of receipt of a written request from Covered Entity, Business Associate shall make available during normal business hours at its offices all records, books, agreements, policies and procedures relating to the use and disclosure of PHI to the Covered Entity, for purposes of enabling Covered Entity to determine Business Associate's compliance with the terms of the Agreement.

g. Within ten (10) business days of receiving a written request from Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to the Covered Entity, or as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR Section 164.524.

h. Within ten (10) business days of receiving a written request from Covered Entity for an amendment of PHI or a record about an individual contained in a Designated Record Set, the Business Associate shall make such PHI available to Covered Entity for amendment and incorporate any such amendment to enable Covered Entity to fulfill its obligations under 45 CFR Section 164.526.

i. Business Associate shall document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

j. Within ten (10) business days of receiving a written request from Covered Entity for a request for an accounting of disclosures of PHI, Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill its obligations to provide an accounting of disclosures with respect to PHI in accordance with 45 CFR Section 164.528.

k. In the event any individual requests access to, amendment of, or accounting of PHI directly from the Business Associate, the Business Associate shall within two (2) business days forward such request to Covered Entity. Covered Entity shall have the responsibility of responding to forwarded requests. However, if forwarding the individual's request to Covered Entity would cause Covered Entity or the Business Associate to violate HIPAA and the Privacy and Security Rule, the Business Associate shall instead respond to the individual's request as required by such law and notify Covered Entity of such response as soon as practicable.

l. Within ten (10) business days of termination of the Agreement, for any reason, the Business Associate shall return or destroy, as specified by Covered Entity, all PHI received from, or created or received by the Business Associate in connection with the Agreement, and shall not retain any copies or back-up tapes of such PHI. If return or destruction is not feasible, or the disposition of the PHI has been otherwise agreed to in the Agreement, Business Associate shall continue to extend the protections of the Agreement, to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business

Contractor Initials ICAP

Date 5/18/2022

Associate maintains such PHI. If Covered Entity, in its sole discretion, requires that the Business Associate destroy any or all PHI, the Business Associate shall certify to Covered Entity that the PHI has been destroyed.

(4) Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any changes or limitation(s) in its Notice of Privacy Practices provided to individuals in accordance with 45 CFR Section 164.520, to the extent that such change or limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall promptly notify Business Associate of any changes in, or revocation of permission provided to Covered Entity by individuals whose PHI may be used or disclosed by Business Associate under this Agreement, pursuant to 45 CFR Section 164.506 or 45 CFR Section 164.508.

c. Covered entity shall promptly notify Business Associate of any restrictions on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(5) Termination for Cause

In addition to Paragraph 10 of the standard terms and conditions (P-37) of this Agreement the Covered Entity may immediately terminate the Agreement upon Covered Entity's knowledge of a breach by Business Associate of the Business Associate Agreement set forth herein as Exhibit I. The Covered Entity may either immediately terminate the Agreement or provide an opportunity for Business Associate to cure the alleged breach within a timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(6) Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the Privacy and Security Rule, amended from time to time. A reference in the Agreement, as amended to include this Exhibit I, to a Section in the Privacy and Security Rule means the Section as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take such action as is necessary to amend the Agreement, from time to time as is necessary for Covered Entity to comply with the changes in the requirements of HIPAA, the Privacy and Security Rule, and applicable federal and state law.

c. Data Ownership. The Business Associate acknowledges that it has no ownership rights with respect to the PHI provided by or created on behalf of Covered Entity.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be resolved to permit Covered Entity to comply with HIPAA, the Privacy and Security Rule.

e. Segregation. If any term or condition of this Exhibit I or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Exhibit I are declared severable.

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

Department of Health and Human Services	White Mountain Community Healt Center
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Iain Watt	Kenneth Porter
Name of Authorized Representative	Name of Authorized Representative
Deputy Director - DPHS	ED
Title of Authorized Representative	Title of Authorized Representative
5/25/2022	5/18/2022
Date	Date

CERTIFICATION REGARDING THE FEDERAL FUNDING ACCOUNTABILITY AND TRANSPARENCY ACT (FFATA) COMPLIANCE

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $25,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $25,000 or more. If the initial award is below $25,000 but subsequent grant modifications result in a total award equal to or over $25,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

1. Name of entity
2. Amount of award
3. Funding agency
4. NAICS code for contracts / CFDA program number for grants
5. Program source
6. Award title descriptive of the purpose of the funding action
7. Location of the entity
8. Principle place of performance
9. Unique identifier of the entity (DUNS #)
10. Total compensation and names of the top five executives if:
    - 10.1. More than 80% of annual gross revenues are from the Federal government, and those revenues are greater than $25M annually and
    - 10.2. Compensation information is not already available through reporting to the SEC.

Prime grant recipients must submit FFATA required data by the end of the month, plus 30 days, in which the award or award amendment is made.
The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of The Federal Funding Accountability and Transparency Act, Public Law 109-282 and Public Law 110-252, and 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:
The below named Contractor agrees to provide needed information as outlined above to the NH Department of Health and Human Services and to comply with all applicable provisions of the Federal Financial Accountability and Transparency Act.

Contractor Name:

DocuSigned by:
[redacted]
Name: Kenneth Porter
Title: ED

5/18/2022
Date

Contractor Initials DS KRP
Date 5/18/2022

FORM A

As the Contractor identified in Section 1.3 of the General Provisions, I certify that the responses to the below listed questions are true and accurate.

1. The DUNS number for your entity is: 5/18/2022

2. In your business or organization's preceding completed fiscal year, did your business or organization receive (1) 80 percent or more of your annual gross revenue in U.S. federal contracts, subcontracts, loans, grants, sub-grants, and/or cooperative agreements; and (2) $25,000,000 or more in annual gross revenues from U.S. federal contracts, subcontracts, loans, grants, subgrants, and/or cooperative agreements?

   X NO _____ YES

   If the answer to #2 above is NO, stop here

   If the answer to #2 above is YES, please answer the following:

3. Does the public have access to information about the compensation of the executives in your business or organization through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C.78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986?

   _____ NO _____ YES

   If the answer to #3 above is YES, stop here

   If the answer to #3 above is NO, please answer the following:

4. The names and compensation of the five most highly compensated officers in your business or organization are as follows:

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

The following terms may be reflected and have the described meaning in this document:

1. "Breach" means the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic. With regard to Protected Health Information, " Breach" shall have the same meaning as the term "Breach" in section 164.402 of Title 45, Code of Federal Regulations.

2. "Computer Security Incident" shall have the same meaning "Computer Security Incident" in section two (2) of NIST Publication 800-61, Computer Security Incident Handling Guide, National Institute of Standards and Technology, U.S. Department of Commerce.

3. "Confidential Information" or "Confidential Data" means all confidential information disclosed by one party to the other such as all medical, health, financial, public assistance benefits and personal information including without limitation, Substance Abuse Treatment Records, Case Records, Protected Health Information and Personally Identifiable Information.

   Confidential Information also includes any and all information owned or managed by the State of NH - created, received from or on behalf of the Department of Health and Human Services (DHHS) or accessed in the course of performing contracted services - of which collection, disclosure, protection, and disposition is governed by state or federal law or regulation. This information includes, but is not limited to Protected Health Information (PHI), Personal Information (PI), Personal Financial Information (PFI), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

4. "End User" means any person or entity (e.g., contractor, contractor's employee, business associate, subcontractor, other downstream user, etc.) that receives DHHS data or derivative data in accordance with the terms of this Contract.

5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

6. "Incident" means an act that potentially violates an explicit or implied security policy, which includes attempts (either failed or successful) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic

mail, all of which may have the potential to put the data at risk of unauthorized access, use, disclosure, modification or destruction.

7. "Open Wireless Network" means any network or segment of a network that is not designated by the State of New Hampshire's Department of Information Technology or delegate as a protected network (designed, tested, and approved, by means of the State, to transmit) will be considered an open network and not adequately secure for the transmission of unencrypted PI, PFI, PHI or confidential DHHS data.

8. "Personal Information" (or "PI") means information which can be used to distinguish or trace an individual's identity, such as their name, social security number, personal information as defined in New Hampshire RSA 359-C:19, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

9. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164, promulgated under HIPAA by the United States Department of Health and Human Services.

10. "Protected Health Information" (or "PHI") has the same meaning as provided in the definition of "Protected Health Information" in the HIPAA Privacy Rule at 45 C.F.R. § 160.103.

11. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and amendments thereto.

12. "Unsecured Protected Health Information" means Protected Health Information that is not secured by a technology standard that renders Protected Health Information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information except as reasonably necessary as outlined under this Contract. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a

request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.

3. If DHHS notifies the Contractor that DHHS has agreed to be bound by additional restrictions over and above those uses or disclosures or security safeguards of PHI pursuant to the Privacy and Security Rule, the Contractor must be bound by such additional restrictions and must not disclose PHI in violation of such additional restrictions and must abide by any additional security safeguards.
4. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.
5. The Contractor agrees DHHS Data obtained under this Contract may not be used for any other purposes that are not indicated in this Contract.
6. The Contractor agrees to grant access to the data to the authorized representatives of DHHS for the purpose of inspecting to confirm compliance with the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If End User is transmitting DHHS data containing Confidential Data between applications, the Contractor attests the applications have been evaluated by an expert knowledgeable in cyber security and that said application's encryption capabilities ensure secure transmission via the internet.
2. Computer Disks and Portable Storage Devices. End User may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS data.
3. Encrypted Email. End User may only employ email to transmit Confidential Data if email is encrypted and being sent to and being received by email addresses of persons authorized to receive such information.
4. Encrypted Web Site. If End User is employing the Web to transmit Confidential Data, the secure socket layers (SSL) must be used and the web site must be secure. SSL encrypts data transmitted via a Web site.
5. File Hosting Services, also known as File Sharing Sites. End User may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. End User may only transmit Confidential Data via *certified* ground mail within the continental U.S. and when sent to a named individual.
7. Laptops and PDA. If End User is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. End User may not transmit Confidential Data via an open

wireless network. End User must employ a virtual private network (VPN) when remotely transmitting via an open wireless network.

9. Remote User Communication. If End User is employing remote communication to access or transmit Confidential Data, a virtual private network (VPN) must be installed on the End User's mobile device(s) or laptop from which information will be transmitted or accessed.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If End User is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If End User is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain the data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have 30 days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or permitted under this Contract. To this end, the parties must:

A. Retention

1. The Contractor agrees it will not store, transfer or process data collected in connection with the services rendered under this Contract outside of the United States. This physical location requirement shall also apply in the implementation of cloud computing, cloud service or cloud storage capabilities, and includes backup data and Disaster Recovery locations.
2. The Contractor agrees to ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting Department confidential information.
4. The Contractor agrees to retain all electronic and hard copies of Confidential Data in a secure location and identified in section IV. A.2
5. The Contractor agrees Confidential Data stored in a Cloud must be in a FedRAMP/HITECH compliant solution and comply with all applicable statutes and regulations regarding the privacy and security. All servers and devices must have currently-supported and hardened operating systems, the latest anti-viral, anti-hacker, anti-spam, anti-spyware, and anti-malware utilities. The environment, as a

whole, must have aggressive intrusion-detection and firewall protection.

6. The Contractor agrees to and ensures its complete cooperation with the State's Chief Information Officer in the detection of any security vulnerability of the hosting infrastructure.

B. Disposition

1. If the Contractor will maintain any Confidential Information on its systems (or its sub-contractor systems), the Contractor will maintain a documented process for securely disposing of such data upon request or contract termination; and will obtain written certification for any State of New Hampshire data destroyed by the Contractor or any subcontractors as a part of ongoing, emergency, and or disaster recovery operations. When no longer in use, electronic media containing State of New Hampshire data shall be rendered unrecoverable via a secure wipe program in accordance with industry-accepted standards for secure deletion and media sanitization, or otherwise physically destroying the media (for example, degaussing) as described in NIST Special Publication 800-88, Rev 1, Guidelines for Media Sanitization, National Institute of Standards and Technology, U. S. Department of Commerce. The Contractor will document and certify in writing at time of the data destruction, and will provide written certification to the Department upon request. The written certification will include all details necessary to demonstrate data has been properly destroyed and validated. Where applicable, regulatory and professional standards for retention requirements will be jointly evaluated by the State and Contractor prior to destruction.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

A. Contractor agrees to safeguard the DHHS Data received under this Contract, and any derivative data or files, as follows:

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.
2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

3. The Contractor will maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

4. The Contractor will ensure proper security monitoring capabilities are in place to detect potential security events that can impact State of NH systems and/or Department confidential information for contractor provided systems.

5. The Contractor will provide regular security awareness and education for its End Users in support of protecting Department confidential information.

6. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will maintain a program of an internal process or processes that defines specific security expectations, and monitoring compliance to security requirements that at a minimum match those for the Contractor, including breach notification requirements.

7. The Contractor will work with the Department to sign and comply with all applicable State of New Hampshire and Department system access and authorization policies and procedures, systems access forms, and computer use agreements as part of obtaining and maintaining access to any Department system(s). Agreements will be completed and signed by the Contractor and any applicable sub-contractors prior to system access being authorized.

8. If the Department determines the Contractor is a Business Associate pursuant to 45 CFR 160.103, the Contractor will execute a HIPAA Business Associate Agreement (BAA) with the Department and is responsible for maintaining compliance with the agreement.

9. The Contractor will work with the Department at its request to complete a System Management Survey. The purpose of the survey is to enable the Department and Contractor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the Contractor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the Contractor, or the Department may request the survey be completed when the scope of the engagement between the Department and the Contractor changes.

10. The Contractor will not store, knowingly or unknowingly, any State of New Hampshire or Department data offshore or outside the boundaries of the United States unless prior express written consent is obtained from the Information Security Office leadership member within the Department.

11. Data Security Breach Liability. In the event of any security breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from

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the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

12. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of requirements applicable to federal agencies, including, but not limited to, provisions of the Privacy Act of 1974 (5 U.S.C. § 552a), DHHS Privacy Act Regulations (45 C.F.R. §5b), HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) that govern protections for individually identifiable health information and as applicable under State law.

13. Contractor agrees to establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality of the Confidential Data and to prevent unauthorized use or access to it. The safeguards must provide a level and scope of security that is not less than the level and scope of security requirements established by the State of New Hampshire, Department of Information Technology. Refer to Vendor Resources/Procurement at https://www.nh.gov/doit/vendor/index.htm for the Department of Information Technology policies, guidelines, standards, and procurement information relating to vendors.

14. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer and the State's Security Officer of any security breach immediately, at the email addresses provided in Section VI. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

15. Contractor must restrict access to the Confidential Data obtained under this Contract to only those authorized End Users who need such DHHS Data to perform their official duties in connection with purposes identified in this Contract.

16. The Contractor must ensure that all End Users:
    a. comply with such safeguards as referenced in Section IV A. above, implemented to protect Confidential Information that is furnished by DHHS under this Contract from loss, theft or inadvertent disclosure.
    b. safeguard this information at all times.
    c. ensure that laptops and other electronic devices/media containing PHI, PI, or PFI are encrypted and password-protected.
    d. send emails containing Confidential Information only if encrypted and being sent to and being received by email addresses of persons authorized to receive such information.

e. limit disclosure of the Confidential Information to the extent permitted by law.

f. Confidential Information received under this Contract and individually identifiable data derived from DHHS Data, must be stored in an area that is physically and technologically secure from access by unauthorized persons during duty hours as well as non-duty hours (e.g., door locks, card keys, biometric identifiers, etc.).

g. only authorized End Users may transmit the Confidential Data, including any derivative files containing personally identifiable information, and in all cases, such data must be encrypted at all times when in transit, at rest, or when stored on portable media as required in section IV above.

h. in all other instances Confidential Data must be maintained, used and disclosed using appropriate safeguards, as determined by a risk-based assessment of the circumstances involved.

i. understand that their user credentials (user name and password) must not be shared with anyone. End Users will keep their credential information secure. This applies to credentials used to access the site directly or indirectly through a third party application.

Contractor is responsible for oversight and compliance of their End Users. DHHS reserves the right to conduct onsite inspections to monitor compliance with this Contract, including the privacy and security requirements provided in herein, HIPAA, and other applicable laws and Federal regulations until such time the Confidential Data is disposed of in accordance with this Contract.

V. LOSS REPORTING

The Contractor must notify the State's Privacy Officer and Security Officer of any Security Incidents and Breaches immediately, at the email addresses provided in Section VI.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with the agency's documented Incident Handling and Breach Notification procedures and in accordance with 42 C.F.R. §§ 431.300 - 306. In addition to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and

5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

Incidents and/or Breaches that implicate PI must be addressed and reported, as applicable, in accordance with NH RSA 359-C:20.

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

Attachment #1 - Evaluation of Social Determinants of Health

Enabling Service Work Plan White Mountain Community Health Center Julie Hill, RN, Director of Operations			
Enabling Service Focus Area: Evaluation of Social Determinants of Health			
Project Goal: Screen patients for social determinants of health. **Project Objective:** 60% of patients seen for a medical visit will be screened annually for social determinants of health during the reporting period.			
Activities	**Staff/resources involved**	**Evaluation plans**	**Timeline for activity**
• CCSA (Comprehensive Core Standardized Assessment) of SDOH form by age group will be readily available in front office and in digital format on the patient portal. • CHW to review provider schedules and identify all patients who need to complete CCSA profile. • Front desk staff will distribute CCSA profile to patients at registration. • MAs collect CCSA profile for patient's provider to evaluate. • Socially vulnerable patients will be referred to Social Worker, RN Case Manager or CHW based on risk score.	• CCSA Profile • Reception staff • Pediatric provider • RN Case Manager • FNP provider • MAs • Social worker • CHWs • Clinical coordinator • Patient portal • EMR	Written procedure for referral to home visiting services will be established. Number of referrals will be tracked by referral coordinator. Number of outreach encounters by Social Workers and CHWs to be tracked.	By 8/10/2022 To begin by 9/1/2022 To begin by 9/1/2022

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Attachment #2 - Home Visiting Referrals

Enabling Service Work Plan
White Mountain Community Health Center
Julie Hill, RN, Director of Operations

Enabling Service Focus Area: Home visiting referrals

Project Goal: Increase referrals of qualifying children and families to home visiting services.
Project Objective: Establish a referral procedure to link qualifying families to home visiting services.

Activities	Staff/resources involved	Evaluation plans	Timeline for activity
• Identify qualifying children and families • Create referral procedure • Conduct outreach and education to qualifying families • Refer families to program.	• Pediatric provider • FNP provider • Pediatric MA • Social worker • CHW • Clinical coordinator • Transportation- taxi service and outreach worker travel allowance • Phone and mailing for patient communication and outreach • Referral coordinator • EMR	Written procedure for referral to home visiting services will be established. Number of referrals will be tracked by referral coordinator. Number of outreach encounters by Social Workers and CHWs to be tracked.	By 8/10/2022 To begin by 9/1/2022 To begin by 9/1/2022

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

Due Dates	Reporting Requirements
SFY 23 (July 1, 2022-June 30, 2023	
July 31, 2022	**SFY23 BASELINE REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2021-June 30, 2022) • Set Agency Targets for each measure based on your organization's baseline data. These targets will be effective with data reporting that is due in January 2023. • Complete July 2022 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service work plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
January 31, 2023	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2022-December 31, 2022) • Complete January 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2023	• Corrective Action Plan(s) (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
SFY 24 (July 1, 2023 – June 30, 2024)	
July 31, 2023	**SFY23 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2022-June 30, 2023) • Complete July 2023 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
September 1, 2023	• Corrective Action Plan(s) (Performance Measure Outcome Report) for measures not meeting targets
January 31, 2024	• Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period January 1, 2023-December 31, 2023) • Complete January 2024 section of each Work Plan progress report (must submit a minimum of 4 Work Plan progress reports, one for

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Attachment #3 - Reporting Requirements Calendar

Maternal Child Health in the Integrated Primary Care Setting

	each enabling service Work Plan objective, and one for each QI Work Plan) • Submit any revisions as needed to Work Plans/timelines
March 31, 2024	• Corrective Action Plan (Performance Measures Outcome Report-PMOR) for measures not meeting targets • UDS Data
July 31, 2024	**SFY24 END OF THE YEAR REPORTING** • Primary Care Services Performance Measure Data Trend Table (DTT) (measurement period July 1, 2023-June 30, 2024) • Complete July 2024 section of each Work Plan progress report (should submit a minimum of 4 Work Plan progress reports, one for each enabling service Work Plan objective, and one for each QI Work Plan)

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Attachment #4 - Adolescent Well-Care Visits

Quality Improvement Work Plan White Mountain Community Health Center Julie Hill, RN, Director of Operations			
MCH Performance Measure: Percentage of Adolescents 12-21, who had at least one comprehensive well-care visit with a PCP or an OBGYN practioner during the measurement year.			
Project Objective: To provide well care visits to 60% of adolescents age 12-21 who are due for an exam each quarter.			
Activities	**Staff/resources involved**	**Evaluation plans**	**Timeline for activity**
• QI Data Analyst will run adolescent well-care rule by the 10th of each month to identify overdue patients. ID dental-only patients on list and remove them. • Front desk staff and pediatric clinical team will assess status of most recent wellness exam when a patient presents for visits other than wellness and will schedule a visit if patient is identified as not being up to date. Community Health Worker or Front Desk staff to send reminder postcards to overdue patients	• **APRNs/PA** • **CHW** • **QI Data analyst** • **Social worker** • **MAs/RNs** • **EMR** • **front desk staff** • **UpDox patient reminder platform** • **QI committee**	• Adolescent well-care report will quantify results. • QI Data Analyst will collaborate with Clinical Coordinator, Director of Operations and/or Medical Director to evaluate need for change. • QI team may use PDSA cycles and/or root cause analysis to evaluate issues and establish course of action.	

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Attachment #5 - Depression Screening

Quality Improvement Work Plan White Mountain Community Health Center Julie Hill, RN, Director of Operations			
MCH Performance Measure: Depression Screening: Measure 4A MCH Primary Care measure and HRSA UDS measure.			
Project Objective: Increase depression screening and follow up of patients age 12 and older to >55% by 1/1/2023, and maintain screening at or above 55% thereafter.			
Activities	**Staff/resources involved**	**Evaluation plans**	**Timeline for activity**
AM huddle for all clinical teams to include assessing flow sheets of all patients who do not have a current dx of depression for depression screening done within one year. List of patients needing screening will be given to check in staff, who will distribute screening tool to patients.	• Reception staff • MA/Provider/RN team • AUDIT/DAST/CCS A screening tools • EMR	• DEPSCRN report Observation and reporting of screening lists presented to check in staff by front office manager.	

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Attachment #6 – Performance Measures

1. Definitions

1.1. **Measurement Year** – Measurement Year consists of 365 days and is defined as either:

1.1.1. The calendar year, (January 1st through December 31st); or

1.1.2. The state fiscal year (July 1st through June 30th).

1.2. **Medical Visit** – Medical visit is defined as any office visit including all well-care and acute-care visits.

1.3. **HEDIS** – Healthcare Effectiveness Data and Information Set

1.4. **NQF** – National Quality Forum

1.5. **Title V** – Federal Maternal and Child Health Services Block Grant

1.6. **UDS** – Uniform Data System. UDS measures included below are intended to align with UDS criteria. In the event the criteria for these UDS based measures are revised during the contract period by UDS, the intention is that Contractors would accordingly go by the most up to date UDS guidance for these measures.

1.7. **NH MCHS** – New Hampshire Maternal and Child Health Section

2. NH MCHS PRIMARY CARE PERFORMANCE MEASURES

2.1. **Breastfeeding**

2.1.1. Percent of infants who are ever breastfed (Title V PM #4).

2.1.1.1. Numerator: All patient infants who were ever breastfed or received breast milk.

2.1.1.2. Numerator Note: The American Academy of Pediatrics recommends all infants exclusively breastfeed for about six (6) months as human milk supports optimal growth and development by providing all required nutrients during that time.

2.1.1.3. Denominator: All patient infants born in the measurement year.

2.2. **Preventive Health: Lead Testing**

This measure will be broken down in to two age based measures, based on current NH Legislation, RSA 130-A:5-a, which requires that children be tested for lead at age 1 as well as at age 2.

Age 1 Measure:

2.2.1. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCHS).

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2.2.1.1. Numerator: All children who received at least one capillary or venous blood lead test between twelve (12) months through twenty three (23) months of age.

2.2.1.2. Denominator: All children who turned twenty-four months of age during the measurement year that had at least one (1) medical visit during the measurement year.

Age 2 Measure

2.2.2. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCHS).

2.2.2.1. Numerator: All children who received at least one capillary or venous blood lead test between twenty-four (24) through thirty-six (36) months of age.

2.2.2.2. Denominator: All children who turned 36 months of age during the measurement year that had at least one (1) medical visit during the measurement year.

2.3. **Preventive Health: Adolescent Well-Care Visit**

2.3.1. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).

2.3.1.1. Numerator: Number of adolescents, ages 12 through 21 years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year.

2.3.1.2. Denominator: Number of patient adolescents, ages 12 through 21 years of age by the end of the measurement year.

2.4. **Preventive Health: Depression Screening**

2.4.1. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).

2.4.1.1. Numerator: Patients twelve (12) years and older who are screened for clinical depression using an age-appropriate standardized depression screening tool **AND** if positive, a follow-up plan documented.

2.4.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented follow-up plan.

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2.4.1.3. Denominator: All patients twelve (12) years and older by the end of the measurement year who had at least one (1) medical visit during the measurement year.

2.4.1.4. Denominator Exception: Depression screening not performed due to medical contraindicated or patient refusal.

2.4.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as suicide risk assessment and/or referral to practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

2.4.2. Maternal Depression Screening

2.4.2.1. Percentage of women who are screened for clinical depression during any visit up to twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if positive, a follow-up plan is documented on the date of the positive screen (NH MCHS).

2.4.2.1.1. Numerator: Women who are screened for clinical depression during the first twelve (12) weeks following delivery using an appropriate standardized depression screening tool **AND** if screened positive have documented follow-up plan.

2.4.2.1.2. Numerator Note: Numerator includes women who screened negative **PLUS** women who screened positive **AND** have documented follow-up plan.

2.4.2.1.3. Denominator: All women who had any office visit up to twelve (12) weeks following delivery during the measurement year.

2.4.2.1.4. Denominator Exception: Documentation of depression screening not performed due to medical contraindicated or patient refusal.

2.4.2.1.5. Follow-Up Plan: Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation such as Suicide Risk Assessment and/or referral to a practitioner who is qualified to diagnose

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and treat depression, and/or notification of primary care provider.

2.5. **Preventive Health: Obesity Screening**

Adult Measure

2.5.1. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period **AND** if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).

2.5.1.1. Normal parameters: BMI ≥ 18.5 and < 25

2.5.1.2. Numerator: Patients with BMI calculated within the measurement year or during the current visit and a follow-up plan documented if the BMI is outside of parameters (Normal BMI + abnormal BMI with documented plan).

2.5.1.3. Follow-Up Plan: Proposed outline of follow-up plan to be conducted as a result of BMI outside of normal parameters. The follow-up plan can include documentation of a future appointment, education, referral (such as registered dietician, nutritionist, occupational therapist, primary care physician, exercise physiologist, mental health provider, surgeon, etc.), prescription of/administration of dietary supplements, exercise counseling, nutrition counseling, etc.

2.5.1.4. Denominator: All patients aged 18 years and older who had at least one (1) medical visit during the measurement year.

Child/Adolescent Measure

2.5.2. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year (UDS).

2.5.2.1. Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.

2.5.2.2. Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting

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year, and were seen by the health center for the first time prior to their 17th birthday.

2.6. **Preventive Health: Tobacco Screening**

2.6.1. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year **AND** who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).

2.6.1.1. Numerator: Number of patients in the denominator for whom documentation demonstrates that patients were queried about their tobacco at least one within the past twelve (12) months AND received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user.

2.6.1.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least two (2) medical visit during the measurement year, OR 1 preventative visit

2.6.1.4. Definitions:

2.6.1.4.1. Tobacco Use: Includes any type of tobacco.

2.6.1.4.2. Cessation Counseling Intervention: Includes counseling or pharmacotherapy.

2.6.2. Percent of pregnant women who are screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCHS).

2.6.2.1. Numerator: Pregnant women who were screened for tobacco use during each trimester in which they were enrolled **AND** who received tobacco cessation counseling intervention if identified as a tobacco user.

2.6.2.2. Numerator Note: Numerator equals queried non-smokers PLUS queried smokers with documented counseling intervention and/or pharmacotherapy.

2.6.2.3. Denominator: All women who were enrolled in the prenatal program and delivered a live birth in the measurement year.

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Attachment #6 – Performance Measures

2.7. **Screening, Brief Intervention, and Referral to Treatment (SBIRT) –Has been separated out in to two separate measures, one for adults and one for adolescents.**

Adult Measure

2.7.1. SBIRT – Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.1.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.1.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.1.3. Denominator: All patients aged 18 years and older during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

Adolescent Measure

2.7.2. SBIRT – Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.2.1. Numerator: Number of patients in the denominator who were screened for substance use, using a formal valid screening tool, during any medical visit **AND** if positive, who received a brief intervention and/or referral to services.

2.7.2.2. Numerator Note: Numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.2.3. Denominator: All patients aged 12-17 years during the measurement year, with at least one (1) medical visit during the measurement year, and with at least two (2) medical visits ever.

2.7.2.4. Definitions:

2.7.2.4.1. Substance Use: Includes any type of alcohol or drug.

2.7.2.4.2. Brief Intervention: Includes guidance or counseling.

2.7.2.4.3. Referral to Services: includes any recommendation of direct referral for substance abuse services.

DS KRP

5/18/2022

Attachment #6 – Performance Measures

2.7.3. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services (NH MCHS).

2.7.3.1. Numerator: Number of women in the denominator who were screened for substance use, using a formal and valid screening tool, during each trimester that they were enrolled in the prenatal program **AND** if positive, received a brief intervention or referral to services

2.7.3.2. Numerator Note: numerator equals screened negative PLUS screened positive who have documented brief intervention and/or referral to services.

2.7.3.3. Denominator: Number of women enrolled in the agency prenatal program and who had a live birth during the measurement year.

2.8 Developmental Screening Measure

Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months (NH MCHS)

2.8.1. Numerator: Number of children who were screened for autism using the M-CHAT OR M-CHAT-R/F at least once between the ages of 16-30 months

2.8.2. Denominator: Children who turned 30 months of age during the reporting period and who had at least (1) medical visit during the measurement year

DS KRP

5/18/2022

Attachment #7 – Performance Measure Outcome Report Template

Instructions for completing this Performance Measure Outcome Report (PMOR):
The Performance Measure Outcome Report (PMOR) is to be completed by your agency and emailed to shari.campbell@dhhs.nh.gov at the intervals specified on the Reporting Calendar.

Please complete the Narrative and Plan for Improvement sections for any of the following measures where your agency did not meet your agency target for the reporting period (July 1, 20XX – June 30, 20XX).

Performance measures:

- Breastfeeding
- Lead Screening for 1 Year Olds
- Lead Screening for 2 Year Olds
- Adolescent well care visit
- Depression screening and follow up plan if positive screening, 12 years and older
- Maternal Depression Screening
- Adults with documented BMI and follow-up plan if BMI outside of normal range
- Children 3-17 with documented BMI, nutrition counseling and physical activity counseling
- Adult tobacco screening and cessation counseling intervention for smokers
- Prenatal Tobacco screening each trimester and cessation counseling intervention for smokers
- SBIRT, Adults
- SBIRT, Adolescents
- SBIRT, Pregnant Women
- Developmental Screening-M-CHAT

* Note: Not met performance measures that have been addressed by your agency SFYXX Work Plan are excluded from this report. For example, the PMOR will omit Adolescent Visit measure for Primary Care Services

1. The Narrative section is to explain what happened during the year i.e. why measure was not met, what barriers/challenges your agency faced, describe any improvement activities that took place during the year to correct along the way, etc.

2. The Plan for Improvement section is to describe what steps your agency will take to achieve your agency target in SFYXX i.e. describe your strategy (PDSA), what will you plan to do differently etc.

3. Please email your completed PMOR **Shari Campbell at shari.campbell@dhhs.nh.gov by the dates indicated in the Reporting Calendar.** If you have any questions about completing this document, please contact Jannell Levine at Jannell.E.Levine@dhhs.nh.gov or 603-856-6449.

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5/18/2022

Attachment #7 – Performance Measure Outcome Report Template

Agency Name: _____ **Completed by:** _____

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

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5/18/2022

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

DS KRP

5/18/2022

Attachment #7 – Performance Measure Outcome Report Template

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Performance Measure Name: _____

Agency Outcome: ___%

Agency Target: ___%

Narrative for Not Meeting Target:

Plan for Improvement:

Please copy above pages/sections as needed to complete for all not met measures.

DS KRP

5/18/2022

State of New Hampshire

Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that WHITE MOUNTAIN COMMUNITY HEALTH CENTER is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on June 01, 1981. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **62590**

Certificate Number: **0005669562**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 14th day of February A.D. 2022.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Angela M. Zakon, do hereby certify that:

1. I am a duly elected Officer of White Mountain Community Health Center.

2. The following is a true copy of a vote taken at a meeting of the Board of Directors of the Agency, duly called and held on June 27, 2019, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Executive Director Kenneth Porter is hereby authorized on behalf of White Mountain Community Health Center to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he may deem necessary, desirable or appropriate.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 5/5/2022

Signature of Elected Officer

Name: Angela M. Zakon
Title: Treasurer

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Heather Clement, CIC
Chalmers Insurance Group - North Conway	PHONE (A/C, No, Ext): (603) 356-6926 FAX (A/C, No): (603) 356-6934
PO Box 2480	E-MAIL ADDRESS: HClement@chalmersInsuranceGroup.com
3277 White Mountain Highway	
North Conway NH 03860	
INSURED	INSURER(S) AFFORDING COVERAGE / NAIC #
White Mountain Community Health Center	INSURER A : Great American Insurance Company
298 White Mountain Highway	INSURER B : Tri-State Insurance Co of Minnesota 31003
	INSURER C : Travelers Indemnity Company 25658
	INSURER D : North American Capacity Insurance Company 25038
Conway NH 03818	INSURER E :
	INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 22/23 Master **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR ☒ Directors & Officers Liability Retention: $2,500 per claim GEN'L AGGREGATE LIMIT APPLIES PER: ☒ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:			EPP2443909	01/01/2022	01/01/2023	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG D&O Liab-Non-Profit	$ $ $ $ $ $ $ 2,000,000
B	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☒ HIRED AUTOS ONLY ☒ NON-OWNED AUTOS ONLY			ADP5419758-12	01/01/2022	01/01/2023	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		UB9H902615	01/01/2022	01/01/2023	☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
D	Data Breach Liability			C-4LQT-070423-CYBER-2022	01/08/2022	01/08/2023	Aggregate Limit Retention per claim	$1,000,000 $2,500

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: DHHS-Contract Unit

Operatoins: Primary Care

CERTIFICATE HOLDER

Department of Health & Human Services
Contracts & Procurement
129 Pleasant Street
Concord NH 03301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

White Mountain Community Health Center

Mission, Vision, and Values

Mission

White Mountain Community Health Center provides the community with affordable access to high-quality, compassionate, individualized healthcare and support services needed to achieve wellness.

Vision

We envision a community where everyone gets the care and support they need to be healthy regardless of financial situation.

Values

AFFORDABLE CARE

We want to ensure that anyone in the community can access the best healthcare, no matter who they are and what resources they have. We welcome all regardless of ability to pay, strive for cost transparency, and look for other ways to help patients overcome barriers to care.

RESPECT

We respect each person we work with as a fellow human being. We take the time necessary to build good relationships with patients. Patients' opinions matter to us and we listen to them and shape their care accordingly. We expect patients to treat us with respect and integrity in return. Staff take the time to build good relationships with each other as well to create a supportive and respectful work culture.

COMPREHENSIVE, INTEGRATED CARE

We provide care for the whole person. Providers work as a team to provide integrated care for patients and connect them with resources to address all factors affecting their ability to achieve health.

PROFESSIONAL EXCELLENCE

We recruit highly skilled staff and provide support and continuing education to ensure our patients get the highest level of care. We evaluate our performance regularly and use data to determine areas of improvement.

DEDICATION

We work hard for our patients and go the extra mile to ensure we are following through. Our patients can depend on us.

COLLABORATION

Our staff collaborate and learn from each other to take full advantage of each staff member's strengths. We work closely with other organizations to address our community's health needs and underlying social determinants of health.

INNOVATION

We lead the way in community healthcare, finding creative ways to provide cutting-edge care with the available resources.

BerryDunn

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

FINANCIAL STATEMENTS

June 30, 2021 and 2020

With Independent Auditor's Report

BerryDunn

INDEPENDENT AUDITOR'S REPORT

Board of Directors
White Mountain Community Health Center

We have audited the accompanying financial statements of White Mountain Community Health Center, which comprise the balance sheets as of June 30, 2021 and 2020, and the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with U.S. generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of White Mountain Community Health Center as of June 30, 2021 and 2020, and the results of its operations, changes in its net assets and its cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

Adoption of New Accounting Standard

As discussed in Note 1 to the financial statements, during the year ended June 30, 2021, White Mountain Community Health Center adopted Financial Accounting Standards Board Accounting Standards Update No. 2014-09, *Revenue from Contracts* (Topic 606), and related guidance. Our opinion is not modified with respect to this matter.

Berry Dunn McNeil & Parker, LLC

Portland, Maine
October 28, 2021

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Balance Sheets

June 30, 2021 and 2020

ASSETS

	2021	2020
Current assets		
Cash and cash equivalents	$ 757,295	$ 676,267
Patient accounts receivable	86,593	101,173
Grants receivable	82,473	80,362
Prepaid expenses	29,390	30,935
Total current assets	955,751	888,737
Investments	352,359	269,228
Assets limited as to use	124,621	36,818
Property and equipment, net	58,449	67,056
Total assets	$ 1,491,180	$ 1,261,839

LIABILITIES AND NET ASSETS

Current liabilities		
Accounts payable and accrued expenses	$ 8,714	$ 8,860
Accrued payroll and related amounts	92,508	73,866
Deferred revenue	45,687	44,305
Provider Relief Funds refundable advance	-	4,759
Paycheck Protection Program refundable advance	234,000	238,000
COVID-19 Emergency Healthcare System Relief Fund loan	312,020	345,000
Total current liabilities and total liabilities	692,929	714,790
Net assets		
Without donor restrictions	673,630	510,231
With donor restrictions	124,621	36,818
Total net assets	798,251	547,049
Total liabilities and net assets	$ 1,491,180	$ 1,261,839

The accompanying notes are an integral part of these financial statements.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Statements of Operations

Years Ended June 30, 2021 and 2020

	2021	2020
Operating revenue		
Patient service revenue	$ 841,839	$ 1,070,070
Provision for bad debts	-	(68,721)
Net patient service revenue	841,839	1,001,349
Grants and other support	529,617	625,336
Provider Relief Funds	4,759	118,507
Paycheck Protection Program	238,000	-
Other operating revenue	3,103	4,829
Net assets released from restriction for operations	10,818	2,487
Total operating revenue	1,628,136	1,752,508
Operating expenses		
Salaries and wages	1,033,726	1,096,501
Benefits	168,371	194,949
Contract services	87,527	123,570
Program supplies	39,369	39,527
Occupancy	78,727	76,250
Other operating expenses	134,056	118,063
Depreciation	19,986	19,746
Interest	334	5,692
Total operating expenses	1,562,096	1,674,298
Operating income	66,040	78,210
Other revenue and gains		
Change in fair value of investments	85,980	(1,345)
Excess of revenue over expenses	152,020	76,865
Net assets released from restriction for capital acquisition	11,379	21,997
Increase in net assets without donor restrictions	$ 163,399	$ 98,862

The accompanying notes are an integral part of these financial statements.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Statements of Changes in Net Assets

Years Ended June 30, 2021 and 2020

	2021	2020
Net assets without donor restrictions		
Excess of revenue over expenses	$ 152,020	$ 76,865
Net assets released from restriction for capital acquisition	11,379	21,997
Increase in net assets without donor restrictions	163,399	98,862
Net assets with donor restrictions		
Contributions	110,000	29,752
Net assets released from restriction for operations	(10,818)	(2,487)
Net assets released from restriction for capital acquisition	(11,379)	(21,997)
Increase in net assets with donor restrictions	87,803	5,268
Change in net assets	251,202	104,130
Net assets, beginning of year	547,049	442,919
Net assets, end of year	$ 798,251	$ 547,049

The accompanying notes are an integral part of these financial statements.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Statements of Cash Flows

Years Ended June 30, 2021 and 2020

	2021	2020
Cash flows from operating activities		
Change in net assets	$ 251,202	$ 104,130
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation	19,986	19,746
Change in fair value of investments	(85,980)	1,345
Contributions for long-term purposes	(35,000)	(29,752)
(Increase) decrease in		
Patient accounts receivable	14,580	7,982
Grants receivable	(2,111)	(261)
Prepaid expenses	1,545	(14,419)
Increase (decrease) in		
Accounts payable and accrued expenses	(146)	(5,197)
Accrued payroll and related expenses	18,642	17,532
Deferred revenue	1,382	213
Provider Relief Funds refundable advance	(4,759)	4,759
Paycheck Protection Program refundable advance	(4,000)	238,000
COVID-19 Emergency Healthcare System Relief Fund loan	(32,980)	345,000
Net cash provided by operating activities	142,361	689,078
Cash flows from investing activities		
Proceeds from sale of investments	40,747	70,007
Purchase of investments	(37,898)	(71,845)
Capital expenditures	(11,379)	(23,293)
Net cash used by investing activities	(8,530)	(25,131)
Cash flows from financing activities		
Contributions for long-term purposes	35,000	29,752
Payments on line of credit	-	(100,000)
Net cash provided (used) by financing activities	35,000	(70,248)
Net increase in cash and cash equivalents and restricted cash	168,831	593,699
Cash and cash equivalents and restricted cash, beginning of year	713,085	119,386
Cash and cash equivalents and restricted cash, end of year	$ 881,916	$ 713,085
Breakdown of cash and cash equivalents and restricted cash, end of year		
Cash and cash equivalents	$ 757,295	$ 676,267
Assets limited as to use	124,621	36,818
	$ 881,916	$ 713,085
Supplemental disclosures of cash flow information		
Cash paid for interest	$ 334	$ 5,692

The accompanying notes are an integral part of these financial statements.

Organization

White Mountain Community Health Center (the Center) is a non-profit corporation organized in New Hampshire. The Center's primary purpose is to provide comprehensive primary and preventative healthcare services to the residents in the town of Conway, New Hampshire, and surrounding communities.

The Center is a Federally Qualified Health Center (FQHC) Look-Alike. While FQHC Look-Alikes do not receive Health Center Program grant funds provided to FQHCs, they are eligible to receive enhanced reimbursement under FQHC Medicare and Medicaid payment methodologies. FQHC Look-Alikes are also eligible to purchase discounted drugs through the 340B Federal Drug Pricing Program.

1. Summary of Significant Accounting Policies

Basis of Presentation

The financial statements of the Center have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which require the Center to report information in the financial statements according to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the Center. These net assets may be used at the discretion of the Center's management and the Board of Directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors and grantors. The donor restrictions are temporary in nature and the restrictions are to be met by actions of the Center or by the passage of time.

Income Taxes

The Center is a public charity under Section 501(c)(3) of the Internal Revenue Code. As a public charity, the Center is exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated the Center's tax positions and concluded that the Center has no unrelated business income or uncertain tax positions that require adjustment to the financial statements.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

COVID-19

In March 2020, the World Health Organization declared coronavirus disease (COVID-19) a global pandemic and the United States federal government declared COVID-19 a national emergency. The Organization implemented an emergency response to ensure the safety of its patients, staff and the community. In adhering to guidelines issued by the Centers for Disease Control and Prevention, the Organization took steps to create safe distances between both staff and patients. All providers received the necessary equipment to allow for medical and behavioral health visits using telehealth. Dental operations were curtailed, open only for emergency care, beginning in March and resumed operations later in the year.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act (PPPHCE) Act established the Provider Relief Fund (PRF) to support healthcare providers in the battle against the COVID-19 outbreak. The PRF is being administered by the U.S. Department of Health and Human Services. The Center received PRF in the amount of $123,266 during the year ended June 30, 2020. These funds are to be used for qualifying expenses and to cover lost revenue due to COVID-19. The PRF are considered conditional contributions and are recognized as income when qualifying expenditures have been incurred. The Center incurred qualifying expenditures and lost revenue of $4,759 and $118,507 during the years ended June 30, 2021 and 2020, respectively. Due to the complexity of the reporting requirements and the continued issuance of clarifying guidance, the amount of income allowed to be recognized may change. Any difference between amounts previously estimated and amounts subsequently determined to be recoverable or payable will be included in income in the year that such amounts become known.

In May 2020, the Center received a loan in the amount of $238,000 pursuant to the Paycheck Protection Program (PPP), a program implemented by the U.S. Small Business Administration (SBA) under the CARES Act and the PPPHCE Act. The PPP is subject to forgiveness, to the extent that the proceeds are used to pay qualifying expenditures during a specific covered period. The Center is following the conditional contribution model to account for the PPP loans. Management determined the conditions for forgiveness were substantially met in 2021 and operating income was recorded at that time. In March 2021, the Center received a second PPP loan in the amount of $234,000 which is also subject to forgiveness; however, management has not yet determined the conditions for forgiveness have been substantially met. The first PPP loan was fully forgiven by the SBA in November 2020 and the second PPP was fully forgiven by the SBA in August 2021.

In May 2020, the Center received a loan in the amount of $345,000 from the COVID-19 Emergency Healthcare System Relief Fund (Relief Loan), a program implemented by the State of New Hampshire, Department of Health and Human Services. The Relief Loan is unsecured, is interest free, and has a maturity date of 180 days after the expiration of the State of Emergency declared by the Governor at which time the loan is due in full. The principal amount of the Relief Loan has the potential to be converted to a grant at the discretion of the Governor if certain criteria are met. During 2021, $32,980 of the Relief Loan was converted to a grant. An additional $112,517 was converted to a grant in July 2021. As of June 30, 2021 it is uncertain whether the Center will have additional qualifying expenditures in fiscal year 2022. If not converted to a grant, the Relief Loan is due within a year; accordingly, the portion not converted to a grant as of June 30, 2021 is reported as a current liability in the balance sheet.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less.

The Center has cash deposits in major financial institutions which exceed federal depository insurance limits. The Center has not experienced losses in such accounts and management believes the credit risk related to these deposits is minimal.

Revenue Recognition and Patient Accounts Receivable

The Center has adopted Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, and related guidance, which provide guidance for revenue recognition. The standard's core principle is that an organization will recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the organization expects to be entitled in exchange for those goods or services. The most significant change from the adoption of the new standard relates to the presentation of implicit price concessions. Under the previous standard, the estimate for amounts not expected to be collected was reflected as provision for bad debts, and presented separately as an offset to net patient service revenue.

Under the new standard, the estimate for amounts not expected to be collected, which is primarily based on historical experience, continues to be recognized as a reduction to net revenue, but not reflected separately as provision for doubtful accounts. Subsequent changes in estimate of collectability due to a change in the financial status of a payer, for example, a bankruptcy, are recognized as bad debt expense and presented as an operating expense, if material. The Center has adopted the provisions of ASU No. 2014-09 for the year ended June 30, 2021 and elected the modified retrospective method; therefore, the financial statements and related notes have been presented accordingly. Under the modified retrospective method, amounts in the comparative period have not been restated and continue to be reported under the accounting standard in effect for that year. The adoption had no effect on net assets at July 1, 2020.

The impact of the adoption on the statement of operations for the year ended June 30, 2021 follows:

	As Reported	Balance before ASU No. 2014-09 Adoption	Effect of Change
Patient service revenue		$ 879,705	
Provision for bad debts		(37,866)	
Net patient service revenue	$ 841,839	$ 841,839	$ -

Patient service revenue is reported at the amount that reflects the consideration to which the Center expects to be entitled in exchange for providing patient care. These amounts are due from patients and third-party payers (including commercial insurers and governmental programs).

Performance obligations are determined based on the nature of the services provided by the Center. The Center measures the performance obligation for medical, behavioral health, dental and ancillary services from the commencement of a face-to-face encounter with a patient to the completion of the encounter. Ancillary services provided the same day as the face-to-face encounter are considered to be part of the performance obligation and are not deemed to be separate performance obligations. The Center measures the performance obligation for contract pharmacy services based on when the prescription is dispensed to the patient. The Center's performance obligations are satisfied at a point in time.

The Center determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payers, discounts provided to uninsured patients in accordance with the Center's sliding fee discount program, and implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies, and historical experience.

Consistent with the Center's mission and FQHC Look-Alike designation, care is provided to patients regardless of their ability to pay. Therefore, the Center has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and amounts the Center expects to collect based on its collection history with those patients.

The Center has determined that the nature, amount, timing and uncertainty of revenue and cash flows are affected by the payer. In assessing collectability, the Center has elected the portfolio approach. The portfolio approach is being used as the Center has a large volume of similar contracts with similar classes of customers (patients). The Center reasonably expects that the effect of applying a portfolio approach to a group of contracts would not differ materially from considering each contract separately. Management's judgment to group the contracts by portfolio is based on the payment behavior expected in each portfolio category. As a result, aggregating all the contracts (which are at the patient level) by the particular payer or group of payers will result in the recognition of the same amount of revenue as applying the analysis at the individual patient level. Payer concentrations are disclosed in Note 7.

The Center bills the patients and third-party payers several days after the services are performed. A summary of payment arrangements follows:

Medicare

The Center is primarily reimbursed for medical and ancillary services based on the lesser of actual charges or prospectively set rates for all FQHC services furnished to a Medicare beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other non-FQHC services are reimbursed based on fee-for-service rate schedules.

Medicaid

The Center is primarily reimbursed for medical and ancillary services based on prospectively set rates for all FQHC services furnished to a Medicaid beneficiary on the same day when an FQHC furnishes a face-to-face FQHC visit. Certain other non-FQHC and dental services are reimbursed based on fee-for-service rate schedules.

Other Payers

The Center has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. Under these arrangements, the Center is reimbursed based on contractually obligated payment rates for each Current Procedural Terminology code, which may be less than the Center's public fee schedule.

Patients

The Center provides care to patients who meet certain criteria under its sliding fee discount program. The Center estimates the costs associated with providing this care by calculating the ratio of total cost to total charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for the sliding fee discount program. The estimated cost of providing services to patients under the Center's sliding fee discount program was approximately $46,136 and $88,454 for the years ended June 30, 2021 and 2020, respectively.

For uninsured patients who do not qualify under the Center's sliding fee discount program, the Organization bills the patient based on the Center's standard rates for services provided. Patient balances are typically due within 30 days of billing; however, the Center does, in certain instances, enter into payment agreements with patients that allow payments in excess of one year. For those cases, the financing component is not deemed to be significant to the contract.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Management believes that the Center is in compliance with all laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in patient service revenue in the year that such amounts become known.

Patient Accounts Receivable

Patient accounts receivable are stated at the amount management expects to collect from outstanding balances.

The Center grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. The accounts receivable from patients and third-party payers, net of contractual allowances, were as follows:

	2021	2020
Governmental plans		
Medicare	34 %	23 %
Medicaid	8 %	12 %
Commercial payers	21 %	15 %
Patient	37 %	50 %
Total	100 %	100 %

Grants Receivable

Grants receivable are stated at the amount management expects to collect from outstanding balances. All such amounts are considered collectible.

A portion of the Center's revenue is derived from cost-reimbursable grants, which are conditioned upon certain performance requirements and/or the incurrence of allowable qualifying expenses. Amounts received are recognized as revenue when the Center has met the performance requirements or incurred expenditures in compliance with specific contract or grant provisions, as applicable. Amounts received prior to incurring qualifying expenditures are reported as deferred revenue.

Subsequent to June 30, 2021, the Center was awarded cost reimbursable grants as follows:

	Amount	Available Through
Primary Care Services for Specific Counties	$ 123,762	March 31, 2022
American Rescue Plan Act Funding for Look-Alikes	955,250	June 30, 2023
Total grant funds available	$ 1,079,012	

The American Rescue Plan Act Funding for Look-Alikes grant was fully awarded to the Center for pre-award costs going back to January 2020. As a result, the full amount of the grant award is available to the Center upon award issuance.

Investments

The Center reports investments at fair value. Investments include assets held for long-term purposes. Accordingly, investments have been classified as non-current assets in the accompanying balance sheet regardless of maturity or liquidity. The Center has established policies governing long-term investments.

The Center has elected the fair value option for valuing its investments, which consolidates all investment performance activity within the other revenue and gains section of the statements of operations. The election was made because the Center believes reporting the activity as a single amount provides a clearer measure of the investment performance.

Investment income and the change in fair value are included in the excess of revenue over expenses, unless otherwise stipulated by the donor or State Law.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility risks. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

Assets Limited As To Use

Assets limited as to use are comprised of donor-restricted cash contributions.

Property and Equipment

Property and equipment are carried at cost, less accumulated depreciation. Maintenance, repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Provision for depreciation is computed using the straight-line method over the useful lives of the related assets. The Center's capitalization policy is applicable for acquisitions greater than $5,000.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which is then treated as cost. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the statements of operations and changes in net assets as net assets released from restriction.

Excess of Revenue Over Expenses

The statements of operations reflect the excess of revenue over expenses. Changes in net assets without donor restrictions which are excluded from the excess of revenue over expenses include contributions of long-lived assets (including assets acquired using contributions which, by donor restriction, were to be used for the purposes of acquiring such assets).

Subsequent Events

For purposes of the preparation of these financial statements, management has considered transactions or events occurring through October 28, 2021, the date that the financial statements were available to be issued. Management has not evaluated subsequent events after that date for inclusion in the financial statements.

2. Availability and Liquidity of Financial Assets

The Center regularly monitors liquidity required to meet its operating needs and other contractual commitments. The Center has various sources of liquidity at its disposal, including cash and cash equivalents and investments.

The Center had working capital of $262,822 and $173,947 at June 30, 2021 and 2020, respectively. The Center had average days (based on normal expenditures) cash and investments on hand of 263 and 209 at June 30, 2021 and 2020, respectively.

Financial assets available for general expenditure within one year were as follows at June 30:

	2021	2020
Cash	$ 757,295	$ 676,267
Patient accounts receivable, net	86,593	101,173
Grants receivable	82,473	80,362
Investments	352,359	269,228
Total financial assets without donor restrictions	1,278,720	1,127,030
Less COVID-19 Emergency Healthcare System Relief Fund loan	312,020	345,000
Financial assets available to meet general expenditures within one year	$ 966,700	$ 782,030

The Center's goal is generally to have, at the minimum, the Health Resources and Services Administration recommended days cash on hand for operations of 30 days and 90 days cash in reserve. Average days cash on hand was higher than the Center's goal due to various COVID related relief payments disclosed in Note 1.

3. Investments and Fair Value Measurement

FASB Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurement*, defines fair value as the price that would be received to sell an asset or paid to transfer a liability (an exit price) in an orderly transaction between market participants and also establishes a fair value hierarchy which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The fair value hierarchy within FASB ASC Topic 820 distinguishes three levels of inputs that may be utilized when measuring fair value:

Level 1: Quoted prices (unadjusted) for identical assets or liabilities in active markets that the entity has the ability to access as of the measurement date.

Level 2: Significant observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active, and other inputs that are observable or can be corroborated by observable market data.

Level 3: Significant unobservable inputs that reflect an entity's own assumptions about the assumptions that market participants would use in pricing an asset or liability.

The following table sets forth by level, within the fair value hierarchy, the Center's investments at fair value measured on a recurring basis:

	Investments at Fair Value at June 30, 2021			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 60	$ -	$ -	$ 60
Exchange traded funds	44,039	-	-	44,039
Mutual funds	308,260	-	-	308,260
Total investments	$ 352,359	$ -	$ -	$ 352,359

	Investments at Fair Value at June 30, 2020			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 43	$ -	$ -	$ 43
Exchange traded funds	34,801	-	-	34,801
Mutual funds	234,384	-	-	234,384
Total investments	$ 269,228	$ -	$ -	$ 269,228

4. Property and Equipment

A summary of property and equipment is as follows at June 30:

	2021	2020
Building improvements	$ 28,879	$ 28,879
Furniture	4,218	44,855
Equipment	417,771	506,810
Total cost	450,868	580,544
Less accumulated depreciation	392,419	513,488
Total cost, less accumulated depreciation	$ 58,449	$ 67,056

5. Line of Credit

The Center had a $100,000 unsecured line of credit available with a local bank through September 30, 2020. Interest on borrowings was charged at Prime plus 2%. The Center is in the process of applying for a new line of credit.

6. Net Assets with Donor Restrictions

Net assets with donor restrictions are temporary in nature and are available for the following purposes at June 30:

	2021	2020
Capital purchases	$ 46,363	26,594
Staff recruitment, retention and training	69,327	-
Program activities	8,931	10,224
Total	$ 124,621	$ 36,818

7. Patient Service Revenue

Patient service revenue is as follows for the years ended June 30:

	2021	2020
Medicaid	$ 426,690	$ 517,871
Medicare	90,436	100,462
Third-party insurance	229,593	276,522
Patient pay	95,120	175,215
Total patient service revenue	841,839	1,070,070
Provision for bad debts	-	(68,721)
Net patient service revenue	$ 841,839	$ 1,001,349

8. Functional Expenses

The financial statements report certain categories of expenses that are attributable to more than one program or supporting function; therefore, these expenses require allocation on a reasonable basis that is consistently applied. As the Center is a service organization, such expenses, which include employee benefits, occupancy, depreciation, interest, and other operating expenses, are allocated between healthcare services and administrative support based on the percentage of direct care wages to total wages.

Expenses related to providing these services are as follows for the years ended June 30:

	Healthcare Services	Administrative Support	Total
2021:			
Salaries and wages	**$ 914,424**	**$ 119,302**	**$ 1,033,726**
Benefits	**148,938**	**19,433**	**168,371**
Contract services	**67,456**	**20,071**	**87,527**
Program supplies	**39,369**	**-**	**39,369**
Occupancy	**69,641**	**9,086**	**78,727**
Other operating expenses	**114,567**	**19,489**	**134,056**
Depreciation	**17,679**	**2,307**	**19,986**
Interest	**295**	**39**	**334**
Total operating expenses	**$ 1,372,369**	**$ 189,727**	**$ 1,562,096**
2020:			
Salaries and wages	$ 981,149	$ 115,352	$ 1,096,501
Benefits	174,440	20,509	194,949
Contract services	90,719	32,851	123,570
Program supplies	39,527	-	39,527
Occupancy	68,228	8,022	76,250
Other operating expenses	101,526	16,537	118,063
Depreciation	17,669	2,077	19,746
Interest	5,093	599	5,692
Total	$ 1,478,351	$ 195,947	$ 1,674,298

9. Malpractice Claims

The Center insures its medical malpractice risks on a claims-made basis. There were no known malpractice claims outstanding at June 30, 2021 which, in the opinion of management, will be settled for amounts in excess of insurance coverage, nor are there any unasserted claims or incidents which require loss accrual. The Center intends to renew coverage on a claims-made basis and anticipates that such coverage will be available.

10. Retirement Plan

The Center has a 403(b) retirement plan covering substantially all employees. Contributions by the Center to the plan amounted to $20,670 and $20,749 for the years ended June 30, 2021 and 2020, respectively.

11. Donations In-Kind

The Memorial Hospital (TMH) provides the Center with office and clinic space located in Conway, New Hampshire at no cost. In-kind contributions from TMH to the Center amounted to $59,004 for the years ended June 30, 2021 and 2020 which is included in grants and other support and occupancy expense in the statements of operations.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

Board Roster January 2022

Name, Office	Profession, Place of Work	Town
Christy Mackie President	Camp and Operations Director Geneva Point Center	Fryeburg, ME
Jen Bella Vice President	Licensed Clinical Social Worker Self-employed	Denmark, ME
Angela Zakon Treasurer	Certified Public Accountant, Supervisor Leone, McDonnell & Roberts	Center Conway, NH
Amy Carter Secretary	Children's Librarian, Program Coordinator Cook Memorial Library	Tamworth, NH
Caitlin Behr	Registered Nurse Memorial Hospital	North Conway, NH
Jack Cradock	Health Care Consultant The Galway Group	Conway, NH
Beth Wheatley Dyson	Episcopal Priest Retired	Conway, NH
Debbie Meader	Program Manager Mount Washington Valley Adult Day Center	Madison, NH

KENNETH PORTER JR

Professional Summary

Skilled senior Navy leader with 33 years of proven progressive leadership of high performing units at sea, shore, and in combat. Seeking position offering new growth opportunities and professional challenges.

Skills

- Proven leader
- Strategic thinker
- High attention to detail
- Clinic management
- Lean Six Sigma
- Calm under pressure
- Leader in Change
- Program evaluator
- Environmental Health and Safety
- Operations management
- Emergency Managment
- Produces leaders
- Strong Computer skills
- Independent duty Corpsman

Work History

Command Master Chief, 2014 to Current

US Navy

- Senior Enlisted Leader for all Naval Reserve assets in the State of Rhode Island
- Training team leader Mid-Atlantic Region
- Senior Mentor for Navy Senior Enlisted Leaders in the United States
- Secretary of Defense Reserve Policy board

Command Master Chief Mid-Atlantic Region, 2011 to 2014

US Navy

- Senior Enlisted Leader for all Navy Reserve personnel attached to 13 states
- Senior Enlisted Leader for 100 Sailors responsible for administration of the region.

Command Master Chief Marine Forces Reserve (MFR), 2008 to 2011

US Navy

- Nationwide Senior Enlisted leadership of all Naval medical assets attached to MFR in every state consisting of thousands of Sailors and Marines
- Senior Enlisted for Medical and Dental support to the entire Marine Force Reserve (MFR)
- Pentagon level process improvement and policy boards
- Advisor to Commanding General
- Multiple law, policy, and manpower boards directly for Chief of Naval Operations and Commandant of the Marine Corps

Command Senior Chief, 2004 to 2008

US Navy

- Medical provider
- Manager of 6 Battalion Aid clinics and 200 plus Corpsman
- Team lead for Antarctic supply mission
- Combat deployment leading multi-national team

Independent Duty Corpsman/Senior Medical Department Representative, 2001 to 2004

USS Sides FFG14/ USSMcClusky FFG41 – US Navy

- Medical provider for two Navy ships with 250 plus crew each
- Medical, Admin, Supply, and Navigational Department Manager of 14 Sailors
- Routine and trauma care
- Combat deployments worldwide
- Leader of 4 training teams
- Only Enlisted Department head responsible for all aspects of an operational medical department.

- Engineering Officer of the watch, Maintenance manager, Damage Control Leader

Regimental Command Chief, 1993 to 2001
US Navy
- Command Chief responsible for management of 160 plus Corpsman providing Medical, Dental, Safety and Occupational Health programs for 960 plus Marines and four clinics
- Operation Desert Storm
- Medical clinic Management
- Preventive, routine, and trauma/combat medical care

Combat Corpsman, 1983 to 1993
US Navy
- Combat Corpsman with various units in the United states.
- Squad level leadership of up to 20 people
- Management of medical supplies
- Training Petty Officer
- Navy Occupational Safety and Health (NAVOSH) program manager

Education

Leadership at the Flag Officer Level: 2011
National Defense University -

MBA: Strategic Leadership, 2010
Touro University International -

Command Master Chief/ Chief of the Boat: 2009
Navy War College -

Bachelor of Science: Health Care Administration, 2008
Touro University International -

Senior Enlisted Leadership: 2007
Navy Senior Enlisted Academy -

Accomplishments

- Active Top Secret (TS/SCI) clearance
- Summa Cum Laude Touro University International MBA
- Legion of Merit (Nations 6th highest award) for leadership at the National level
- Lean Six Sigma
- Various courses in leadership, medical, and process improvement
- Various other personal and campaign awards

Julie Everett Hill, R.N.

[redacted]

Profile

I am a Registered Nurse with a current New Hampshire license, and the director of operations at a rural community health center. I enjoy the dynamic nature of community health nursing, and the opportunity it provides to view the family as a whole when planning and providing care. My interests include asthma education, mental health and nutrition.

Experience

White Mountain Community Health Center, Conway, NH

December 2014-Present: Director of Operations

Coordinate provision of all programs (Family Planning, STD/HIV, BCCSP, Prenatal, Pediatrics, Primary Care, and Teen Clinic). Supervise all clinical, medical records, and front office staff. Coordinate and ensure adequate staffing schedules for clinical staff. Assist in budget preparation as needed. Represent the health center publically at forums and events. Responsible for the implementation of electronic health record and the ongoing customization of the program to ensure appropriate documentation of patient care, meet program reporting needs and facilitate efficient staff workflow across the agency.

2011 to 2014: Director of Clinical Services

Coordinate provision of all programs (Family Planning, STD/HIV, BCCSP, Prenatal, Pediatrics, Primary Care, and Teen Clinic). Supervise all clinical staff. Coordinate and ensure adequate staffing schedules for clinical staff. Perform annual clinical staff evaluations. Assist in budget preparation as needed. Assist Medical Director when seeing patients.

2009-2011: Registered Nurse

Primary care and family planning focus, with patient population newborn through geriatric. Strong focus on patient education, including asthma education and diabetic teaching. Other roles include triage and prioritization of care and coordination of patient care with resources both within and outside of the clinic.

Memorial Hospital, North Conway, NH

June 2007-June 2010: Registered Nurse

Medical Surgical nursing care of a broad range of patients from pediatric to geriatric. Roles included assessment of care of acutely ill patients with medical, surgical and/or orthopedic diagnoses. Patient education, care planning, complete patient assessment and accurate documentation in EMR were integral parts of this position.

May 2006-June 2007: Licensed Practical Nurse

Medical Surgical and some post-partum and newborn nursing care under the supervision of a Registered Nurse.

February 2001-May 2006: LNA/Unit Secretary

Unit Secretary/LNA in fast-paced medical surgical unit. Duties included transcribing doctor's orders, managing patient records, answering and directing phone calls, assisting nurses with order entry and facilitating communication between departments.

Education

Saint Anselm College; Advanced Nursing Leadership Program: 2013
NHCTC, Berlin, NH: Associates Degree in Science, Nursing; May 17, 2007, Phi Theta Kappa Honor Society
Southern Maine Technical College, Portland, ME: Nursing Assistant Certificate 1994
University of Southern Maine: 1992-1993
Certifications and relevant continuing education include:

- North Country Health Consortium Public Health Training Center: Community Health Assessment and Improvement Modules 1-4, 2013
- Yellow Belt- LEAN Systems Training for Quality Improvement: September 2013
- Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) consultant training certificate; June 2013
- Current BLS
- Asthma Educators Institute 2010
- Diabetes Nurse Champion, September 2008
- WIC Breastfeeding Peer Counselor Certification, November 2000

Personal/Community

Mount Washington Valley Toastmasters #3596556: President, Charter member
Swift River CrossFit: CFL1 Trainer

Carol L. Roberts

Current Position with White Mountain Community Health Center is that of:
Finance Manager **Date of Hire: 05/20/2013**

SUMMARY: Comprehensive background in bookkeeping and associated accounting practices including payroll, financial reporting and tax preparation. Sound communication skills. Confident personnel manager with proven experience. Successful ideas person with solid organizational capacity.

ORGANIZATION: Strong implementation skills. Capable of following through on established plans and ideas, putting them to work and making things function. Effective time-manager.

MANAGEMENT: Goal oriented. Clear thinker. Advocate open door policy. Expect high standards. Encourage latitude in staff thinking and motivation, without deviating from sense of purpose.

TECHNICAL: *Quickbooks Pro *Windows Excel & Word
*Various Business Softwares & Retail POS Systems
*Proficient Typist *Acctg Calc skills

PROFESSIONAL BACKGROUND - - - - - - - - - - - - - - - - 1972 - CURRENT

BUSINESS OFFICE MANAGER (08/04 - 05/11/12)
Lovell Hardware & Bldg Supply **Lovell, ME**
While also employed part-time for Center Lovell Market, I held the position of office manager of Lovell Hardware, balancing my time between the two businesses. Duties performed included bi-weekly payroll publishing on QB's and journalizing to a different accounting software. Publishing & mailing of A/R's, bank depositing, posting and payments of A/P's, maintaining the general ledger & producing financials on Eagle accounting-POS program. Continual correspondence with owner to execute effective operations of the business.

BUSINESS OFFICE MANAGER (06/99 - 05/11/12)
Center Lovell Market II, LLC **Center Lovell, ME**
Conducted all business record keeping on QB's Pro including A/P's & payroll processing for three separate companies initially. Maintaining A/R's and inventory on separate data base systems designed for convenience store retailers. Created spread-sheets for cash flow management and budgeting purposes.

ACCOUNTING OFFICE ASST (Seasonal Employ) (2002-'03 & 2003-'04) (2008-'09 & 2009-'10 & 12/05/2011 – 03/29/2013)

Shawnee Peak Holdings Inc **Bridgton, ME**

Intermittantly while employed by the above two businesses, I also held the position of accounting assistant and later as night auditor for a local ski resort. Responsibilities were: Assisted CFO with all daily reporting functions, processed A/P's, assisted with HR functions and delivery of bi-weekly payroll. Developed multi-sheet spreadsheet for effectively getting all cash intake accounted for and distributed to appropriate ledger accounts for financial reporting. As night auditor during the 2008 – '10 work years I balanced down all profit centers reportable to CFO for next day processing & financial reporting. Recent seasonal employment from December 2012 through March 28, 2013 was again in the position of accounting assistant to Jen Holden. I assisted with personnel maintenance, payroll and the same various others functions that I have performed for them during previous seasonal work

ACCOUNTING ASSOCIATE (02/92 - 06/99)

Tower Automotive., Inc. **Traverse City, MI**

Held the position of payroll processor, producing payroll for approximately 400 colleagues for two different payroll classifications –hourly paid bi-weekly & management paid semi-monthly. Responsible for maintaining all employee files, inputting time worked to transmit to ADP (outside payroll service), process and deliver payroll, keep related updates, schedules & personnel records, reconcile/maintain 401k loan accts, make all payroll journal entries to general ledger, plus various other activities, provided support for other accounting & human resource functions.

FINANCIAL DIRECTOR/OFFICE MANAGER (08/90 - 11/91)

The Paper Company **Traverse City, MI**

Conducted all internal record keeping, journalizing & posting of financial activity. Perpared internal support data for compilation of financial reports. Maintained accurate & thorough records while the company was experiencing distressful situations & a change in ownership. This included aborting and/or switching the organizations 2,000 – 2,500 A/R's to three different systems within a seven month period.

FINANCIAL DIRECTOR/OFFICE MANAGER (04/86 - 08/90)

Alpha's of Michigan, Inc. **Traverse City, MI**

Oversaw all financial & operational matters pertaining to the Northern Michigan business office. Supervised staff of seven. Maintained personnel & financial records. Interviewd & hired staff. Assisted marketing & sales department. Promoted positive customer relations.

OFFICE DIRECTOR/MANAGER (07/79 - 04/86)

Mainstream Sports, Inc. **Traverse City, MI**

Maintained all financial records. Produced budget work-ups. Conducted departmental profitability analysis. Designed business projection plans. Implemented cash flow

scheduling. Performed all tax reporting duties. Initiated loan applications for business expansion. Assisted customers.

PAYROLL CLERK **(07/78 - 06/79)**

Munson Medical Center **Traverse City, MI**

Prepared payroll for 1,000 employees. Performed profile adjustments & changes. Produced wage distribution reports. Initiated tax reports. Maintained personnel files. Assisted with employment procedures

HEAD BOOKKEEPER **(11/72 - 06/77)**

Tom's Food Markets, Inc. **Traverse City, MI**

Administered payroll. Maintained personnel records. Oversaw A/R's & A/P's. Produced store reports. Performed check register balancing. Initiated misc reporting & computation. Assisted customers.

OVERVIEW: I have a very impressive work ethic as depicted in my employment history. Besides the listing above, I also seasonally worked a third job as night auditor for a local ski resort. My adaptability to any situation touts employability. I'm a good organizer with strong self-management capabilities.

CONTRACTOR NAME

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

MCH – Primary Care - Plan Year FY22-23
April 18, 2022 thru 06-30-2022
July 1, 2022 thru 06-30-2023
July 1, 2023 thru 06-30-24

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Porter, Kenneth R. Jr	Executive Director, Contract Executor	$98,280	0.0	0.00
Hill, JulieAnn E.	Dir. of Operations, Plan Admin	$83,200	25.0	$20,800
Roberts, Carol L.	Finance Mngr, Invoicing	$58,240	0.0	0.0

***As requested by Siena Kaplan-Thompson on 05/26/22 to include in document package she is preparing to furnish to dhhs… CLR