Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-4501 1-800-852-3345 Ext. 4501
Fax: 603-271-4827 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

March 31, 2021

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

INFORMATIONAL ITEM

Pursuant to RSA 4:45, RSA 21-P:43, and Section 4 of Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, 2020-24, 2020-25, 2021-01, 2021-02, 2021-04, and 2021-05, Governor Sununu has authorized the Department of Health and Human Services, Division of Public Health Services, to enter into **Retroactive, Sole Source** amendments to existing agreements with the Contractors listed below by increasing the price limitation by $5,775,200 from $3,727,800 to $9,503,000 for COVID-19 surveillance testing for staff in long-term care facilities, with no change to the agreement completion date of December 30, 2020, effective retroactive to December 1, 2020. 100% Other Funds (Governor's Office for Emergency Relief and Recovery).

The original contracts were approved by the Governor on November 20, 2020, and will be presented to the Executive Council as an informational item on February 3, 2021 (Item #J).

Contractor Name*	Vendor Code	Current - Individual Price Limitation	Current - Shared Price Limitation	Increase (Decrease) - Individual Price Limitation	Increase (Decrease) - Shared Price Limitation	Revised - Individual Price Limitation	Revised - Shared Price Limitation	Revised - Total Price Limitation*
Greenbriar Operations, LLC.	284076	$79,100	Current Total Shared Price Limitation - $0	$70,800	Increased to Shared Price Limitation - $1,874,400	$149,900	Revised Total Shared Price Limitation - $1,874,400	$2,024,300
Bear Mt Hanover, LLC	314699	$27,400		$34,400		$61,800		$1,936,200
Bedford Nursing & Rehabilitation Services, LLC	262015	$29,600		$36,800		$66,400		$1,940,800
Bel-Air Nursing and Rehab Center, Inc.	257972	$22,500		$19,200		$41,700		$1,916,100
Colonial Poplin Nursing Home, Inc.	234608	$29,000		$33,600		$62,600		$1,937,000
County of Belknap	237705	$44,800		$57,600		$102,400		$1,976,800
County of Carroll	233410	$70,500		$62,800		$133,300		$2,007,700
County of Cheshire	232899	$108,000		$97,200		$205,200		$2,079,600

County of Coos	177270	$60,600		$77,200		$137,800		$2,012,200
County of Coos	232841	$60,600		$77,200		$137,800		$2,012,200
County of Hillsborough	233087	$98,000		$0		$98,000		$98,000
County of Grafton	233411	$70,000		$90,000		$160,000		$2,034,400
County of Merrimack	233015	$237,300		$212,400		$449,700		$2,324,100
County of Sullivan	233088	$61,600		$79,200		$140,800		$2,015,200
Edgewood Manor, Inc.	231353	$80,000		$72,000		$152,000		$2,026,400
Franklin Home for the Aged Association	154062	$13,000		$15,600		$28,600		$1,903,000
GENESIS HEALTHCARE HOLDING COMPANY I, INC.	231518	$849,200		$946,400		$1,795,600		$3,670,000
Greenleaf Properties, Inc.	233422	$24,800		$31,600		$56,400		$1,930,800
Hanover Hill Health Care Center Svcs	242754	$56,000		$71,600		$127,600		$2,002,000
Heartland HealthCare Center LLC	257277	$34,600		$40,400		$75,000		$1,949,400
Holy Cross Health Center, Inc.	234399	$25,200		$32,000		$57,200		$1,931,600
Jaffrey Rehabilitation and Nursing Center LLC	305851	$28,000		$24,800		$52,800		$1,927,200
Memorial Elder Health Services	283481	$29,900		$25,600		$55,500		$1,929,900
Merrimac Medical Investors, LLC	240265	$49,600		$62,800		$112,400		$1,986,800
Metro Health Foundation of New Hampshire, Inc.	237706	$74,500		$66,000		$140,500		$2,014,900
New Hampshire Catholic Charities	233250	$233,000		$224,800		$457,800		$2,332,200
NH Odd Fellows Home	233413	$39,200		$50,400		$89,600		$1,964,000
Peak Healthcare at Keene, LLC.	337035	$28,000		$36,000		$64,000		$1,938,400

Peak Healthcare at Portsmouth, LLC.	337037	$53,900		$47,600		$101,500		$1,975,900
Peak Healthcare at Rochester, LLC.	337036	$31,600		$36,800		$68,400		$1,942,800
Pearl Street HealthCare Center LLC	257276	$56,000		$50,400		$106,400		$1,980,800
Peterborough Retirement Community At Upland Farm, Inc.	334149	$58,800		$75,600		$134,400		$2,008,800
Rannie Webster Foundation	231474	$46,600		$59,200		$105,800		$1,980,200
Rockingham County	177468	$116,000		$148,000		$264,000		$2,138,400
Salemhaven, Inc.	233321	$57,900		$51,200		$109,100		$1,983,500
School Street Associates Inc.	233412	$12,400		$14,800		$27,200		$1,901,600
Silverstone by Hunt	305851	$41,000		$52,000		$93,000		$1,967,400
St. Joseph Residence, Inc.	234866	$20,200		$23,600		$43,800		$1,918,200
Strafford County Nursing Home	233530	$150,200		$134,400		$284,600		$2,159,000
Taylor Community	318565	$82,200		$73,200		$155,400		$2,029,800
The Courville at Nashua, Inc.	232813	$28,000		$36,000		$64,000		$1,938,400
The Courville at Manchester, Inc.	232813	$28,000		$36,000		$64,000		$1,938,400
The Morrison Hospital Association	216949	$29,400		$36,800		$66,200		$1,940,600
The Prospect-Woodward Home	325292	$24,200		$30,400		$54,600		$1,929,000
The Riverwoods Group	336365	$143,100		$129,600		$272,700		$2,147,100
United Church of Christ Retirement Community, Inc.	232807	$92,400		$118,800		$211,200		$2,085,600

Villa Crest HealthCare Center LLC	257278	$42,000		$54,000		$96,000		$1,970,400
VK Dover, LLC	249974	$49,900		$44,000		$93,900		$1,968,300
		$3,727,800	$0	$3,900,800		$7,628,600	**$1,874,400**	**$9,503,000**

*Represents the *Revised Individual Price Limitation* plus *Revised Shared Price Limitation.*

Funds are available in the following accounts for State Fiscal Year 2021, 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.

05-95-90-900010-19510000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: PUBLIC HEALTH SERV DIV, ADMINISTRATION, LONG TERM CARE FACILITIES – GOFERR FUNDS

State Fiscal Year	Class / Account	Class Title	Job Number	Current Price Limitation	Increase (Decrease) to Individual Vendor Price Limitation	Revised Price Limitation
2021	103-502507	Contracts for Op Svc	90029000	$3,727,800	$5,775,200	$9,503,000
			Total	**$3,727,800**	**$5,775,200**	**$9,503,000**

EXPLANATION

These amendments are **Retroactive** because the Department, in the interest of public's health and safety, worked with the long-term care facilities to quickly provide necessary additional funding for COVID-19 surveillance testing for their staff and did not have the fully executed agreement documents in time for Governor approval. These amendments are **Sole Source** because the agreements were originally approved as sole source and MOP 150 requires any subsequent amendments to be labeled as sole source. The identified Contractors are the only long-term care facilities in the State of New Hampshire.

The purpose of these amendments is to provide additional funding to long-term care facilities to increase COVID-19 surveillance testing of staff. The State of New Hampshire is experiencing an increase in the COVID-19 positivity rate, which directly affects long-term care facilities. The Contractors will increase surveillance testing based on the positivity rate in their respective counties, per Centers for Medicaid and Medicare requirements. Each long-term care facility will coordinate its staff testing and send the tests to a laboratory. The Department will pay $100 for each COVID-19 surveillance test sent to a laboratory. The Department has agreed to a $1,874,400 shared price limitation among the Contractors for increased surveillance and outbreak testing as needed. The Contractor will also coordinate outbreak testing for residents, which the Department will reimburse for as the payer of last resort.

Approximately 47,000 individuals will be tested from October 12, 2020, through December 30, 2020.

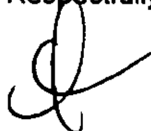
The Contractors will conduct COVID-19 pre-testing, testing, and post-testing functions for staff. The Contractors will collect testing supplies from their contracted laboratories, administer the tests, and ensure all results are reported through the Department's electronic laboratory reporting system.

The Department will monitor contracted services by requiring the Contractors to submit monthly testing reports to ensure all testing is completed.

Areas served: Statewide

Source of Funds: 100% Other Funds (Governor's Office for Emergency Relief and Recovery).

Respectfully submitted,



Lori A. Shibinette
Commissioner

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Greenbriar Operations, LLC. ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:
   - 1.8 Grant Amount not to exceed: $2,024,300
2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:
   - 1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:
     - 1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:
       - 1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.
       - 1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.
       - 1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.
         - 1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.
     - 1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.
       - 1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:
Lisa M. Morris

12/23/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

Greenbriar Operations, LLC.

DocuSigned by:
Katrina Greenhalgh

12/23/2020
Date

Name: Katrina Greenhalgh
Title: Administrator

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $149,900.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,499 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.,
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DocuSigned by:
Initials *Katrina Greenhalgh*
59085A0C514AC9...
Date 12/23/2020

DocuSign Envelope ID: 65D46029-3951-48E7-B822-F20599C1679E

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
KG

Date

12/23/2020

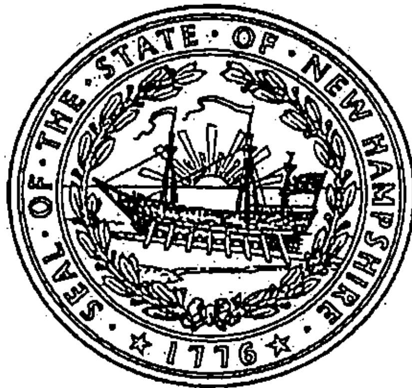
DocuSign Envelope ID: 65D46029-3951-48E7-B822-F20599C1679E

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 GREENBRIAR OPERATIONS LLC is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on September 08, 2020. 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: 850233
Certificate Number : 0005004178



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 8th day of September A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Ari Erlichman, 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 Greenbriar Operations, LLC.
(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 December 21, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

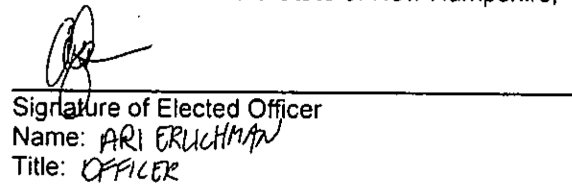
VOTED: That Katrina Greenhalgh, Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Greenbriar Operations LLC 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: 12/21/2020



Signature of Elected Officer
Name: ARI ERLICHMAN
Title: OFFICER

DocuSign Envelope ID: 65D46029-3951-48E7-B822-F20599C1679E

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/16/2020

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	
Fairmont Ins. Brokers, Ltd. 1600 60th Street Brooklyn NY 11204	CONTACT NAME: Andrew Gross PHONE (A/C, No, Ext): (718) 232-3300 FAX (A/C, No): (718) 256-9062 E-MAIL ADDRESS: agross@fairmontins.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: National Fire & Marine	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

Greenbriar Operations LLC DBA Greenbriar Rehab and Healthcare
55 Harris Road
Nashua NH 03062

COVERAGES CERTIFICATE NUMBER: CL20111603834 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; [X] CLAIMS-MADE [ ] OCCUR; [X] GLPL Retro Date 11/1/2020; GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC; OTHER:			NSC100596	11/15/2020	11/15/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 200,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
								$
	AUTOMOBILE LIABILITY; [ ] ANY AUTO; [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS; [ ] HIRED AUTOS ONLY [ ] 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	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			NSC100596	11/15/2020	11/15/2021	Each Occurence	1,000,000
							Aggregate	3,000,000

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

CERTIFICATE HOLDER	CANCELLATION
Proof of Insurance	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

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/23/2020

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	
Fairmont Ins. Brokers, Ltd. 1600 60th Street Brooklyn NY 11204	CONTACT NAME: Rochelle Halperin PHONE (A/C, No, Ext): (718) 232-3300 FAX (A/C, No): (718) 256-9062 E-MAIL ADDRESS: rhalperin@fairmontins.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Atlantic Charter Insurance Company	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

Greenbriar Operations LLC DBA Greenbriar Rehab and Healthcare
55 Harris Road
Nashua NH 03062

COVERAGES **CERTIFICATE NUMBER:** CL20122305120 **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 CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WCA00572300	11/01/2020	11/01/2021	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

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

CERTIFICATE HOLDER	CANCELLATION
Proof of Insurance	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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and BEAR MT HANOVER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,936,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/22/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

BEAR MT HANOVER LLC

12/22/2020
Date

DocuSigned by:
Martha Ilsley
Name: Martha Ilsley
Title: Administrator

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 62,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 622 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials MJ
Date 12/22/2020

DocuSign Envelope ID: E0373F3E-8AB4-42BD-9479-C8771264A7FC

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
MJ

Date

12/22/2020

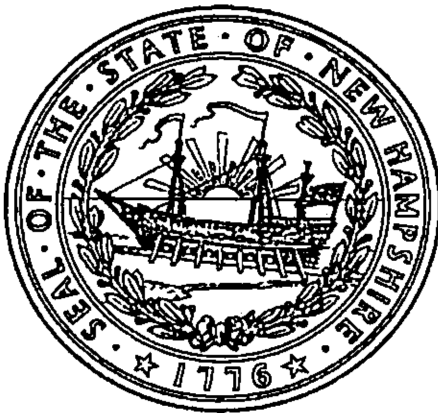
DocuSign Envelope ID: E0373F3E-8AB4-42BD-9479-C8771264A7FC

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 BEAR MT HANOVER LLC is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on March 12, 2019. 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: **814669**
Certificate Number: **0005033915**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 27th day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Scott Ziskin, 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 Bear Mountain Healthcare, LLC.
(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 October 30, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Martha Ilsey, Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of BM Hanover, LLC 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: 12/22/20

Signature of Elected Officer
Name: Scott Ziskin
Title: President & CEO

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/18/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
530 Preston Avenue
Meriden, CT 06450
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No): 203 634-5701
E-MAIL ADDRESS:

INSURED
Bear Mountain Healthcare LLC
PO Box 549
Terryville, CT 06786

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hudson Excess Insurance Company	14484
INSURER B : AIM Mutual Insurance Company	33758
INSURER C : Liberty Surplus Insurance Corporation	10725
INSURER D : Zurich American Insurance Company	16535
INSURER E : Travelers Casualty & Surety	31194
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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE; X OCCUR			HFF1002112001	12/15/2020	12/15/2021	EACH OCCURRENCE	$1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$100,000
	X Professional Liab						MED EXP (Any one person)	$10,000
				HFF1002112001	12/15/2020	12/15/2021	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			BAP7836525	12/15/2020	12/15/2021	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	X 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 Y/N			WRZ80080072092020A	12/15/2020	12/15/2021	PER STATUTE; OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A					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	Oil Tank-Parkway			IRONTX009043761	11/30/2020	11/30/2021	1,000,000	
E	Crime			106796568	12/15/2020	12/15/2021	100,000	

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

Bear Mountain 320 Properties LLC & Bear Mountain 320 Operating LLC
320 Maple Avenue, Great Barrington, MA 01230

Bear Mountain 148 Properties LLC & Bear Mountain 148 Operating LLC
148 Maple Avenue, Great Barrington, MA 01230
(See Attached Descriptions)

CERTIFICATE HOLDER

Proof of Insurance

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

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DESCRIPTIONS (Continued from Page 1)

JACC Management LLC & JACC Healthcare Center of Norwich LLC
60 Crouch Ave, Norwich, CT 06360

JACC Management LLC & JACC Healthcare Center of Windham LLC
595 Valley St, Willimantic, CT 06226

West Roxbury Property Holdings LLC & Bear Mt West Roxbury LLC
5060 Washington St, West Roxbury , MA 02132

Parkway Property Holdings LLC & Bear Mt Parkway LLC
1190 VFW Parkway, West Roxbury, MA 02132

Mattapan Property Holdings LLC & Bear Mt Mattapan LLC
405 River Street, Mattapan, MA 02126

Massachusetts SNF 4 LLC & Bear Mountain Stoughton LLC
1044 Park St, Stoughton MA 02072

Massachusetts SNF 5 LLC & Bear Mountain Newburyport LLC
77 High Street, Newburyport, MA 01950

Massachusetts SNF 6 LLC & Bear Mountain Swansea LLC
2045 Grand Army of the Republic Hwy, Swansea MA 02777

Massachusetts SNF 7 LLC & Bear Mountain Fall River LLC
273-291 Oak Grove Ave, Fall River MA 02723

ssachusetts SNF 8 LLC & Bear Mountain Franklin LLC
.0 Chestnut Street, Franklin MA 02038

New Hampshire SNF 1 LLC & Bear Mountain Hanover LLC
49 Lyme Road, Hanover, NH 03755

CCP Springfield Business Trust, a Massachusetts business trust & Bear Mountain Springfield LLC
215 Bicentennial Hwy, Springfield, MA 01118

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain West Springfield LLC
42 Prospect Ave, West Springfield, MA 01089

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain East Longmeadow LLC
32 Chestnut Street, East Longmeadow, MA 01028

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain Sudbury LLC
136 Boston Post Road, Sudbury, MA 01776

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain Lowell LLC
500 Wentworth Avenue, Lowell, MA 01852

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain Andover LLC
80 Andover Street, Andover, MA 01810

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain Reading LLC
1364 Main Street, Reading, MA 01867

CCP Properties Business Trust, a Massachusetts business trust & Bear Mountain Worcester LLC
59 Acton Street, Worcester, MA 01604

DESCRIPTIONS (Continued from Page 1)

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and BEDFORD NURSING & REHABILIATION SERVICES LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,940,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by: Lisa M. Morris

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

BEDFORD NURSING & REHABILIATION SERVICES LLC

12/18/2020
Date

DocuSigned by: Jeff Miller

Name: Jeff Miller
Title: Administrator

DocuSign Envelope ID: 73E32CFD-08EA-4036-932F-C774ABC6C035

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 66,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 668 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

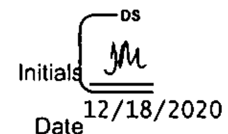
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.



Initials

Date 12/18/2020

DocuSign Envelope ID: 73E32CFD-08EA-4036-932F-C774ABC6C035

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
JM

Date

12/18/2020

Business Information

Business Details

Business Name:	BEDFORD NURSING & REHAB SERVICES, LLC	Business ID:	710969
Business Type:	Domestic Limited Liability Company	Business Status:	Good Standing
Management Style:	Manager Managed		
Business Creation Date:	07/01/2014	Name in State of Formation:	Not Available
Date of Formation in Jurisdiction:	07/01/2014		
Principal Office Address:	480 Donald Street, Bedford, NH, 03110, USA	Mailing Address:	NONE
Citizenship / State of Formation:	Domestic/New Hampshire		
		Last Annual Report Year:	2020
		Next Report Year:	2021
Duration:	Perpetual		
Business Email:	john.turcotte@BNRCenter.com	Phone #:	603-622-4323
Notification Email:	NONE	Fiscal Year End Date:	NONE

Principal Purpose

S.No	NAICS Code	NAICS Subcode
1	OTHER / Provide skilled care residential nursing and rehabilitation services	

Page 1 of 1, records 1 to 1 of 1

Principals Information

Name/Title	Business Address
John M Turcotte / Manager	480 Donald Street, Bedford, NH, 03110, USA

Page 1 of 1, records 1 to 1 of 1

Registered Agent Information

Name: Turcotte, John M

Registered Office Address: 480 Donald Street, Bedford, NH, 03110, USA

Registered Mailing Address: 480 Donald Street, Bedford, NH, 03110, USA

Trade Name Information

Business Name	Business ID	Business Status
BNRC (/online/BusinessInquire/TradeNameInformation?businessID=532693)	711053	Active
Bedford Nursing & Rehabilitation Center (/online/BusinessInquire/TradeNameInformation?businessID=536958)	711048	Active

Trade Name Owned By

Name	Title	Address

Trademark Information

Trademark Number	Trademark Name	Business Address	Mailing Address

No records to view.

Filing History Address History View All Other Addresses Name History Shares

Businesses Linked to Registered Agent Return to Search Back

NH Department of State, 107 North Main St. Room 204, Concord, NH 03301 -- **Contact Us (/online/Home/ContactUS)**

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CERTIFICATE OF AUTHORITY

I, John M. Turcotte, 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 Bedford Nursing & Rehab Services, LLC
(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 December 22, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

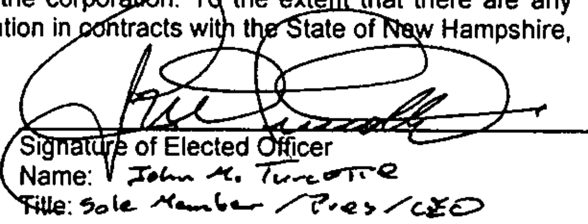
VOTED: That Jeffrey Miller & John Turcotte (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Bedford Nursing & Rehab Services, LLC 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: 12/22/20



Signature of Elected Officer
Name: John M. Turcotte
Title: Sole Member / Pres / CEO

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/07/2020

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	
CGI Business Insurance 5 Dartmouth Drive Auburn NH 03032	CONTACT NAME: Teri Davis PHONE (A/C, No, Ext): (866) 841-4600 FAX (A/C, No): (866) 574-2443 E-MAIL ADDRESS: TDavis@CGIBusinessInsurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : CNA	
INSURER B : National Casualty Company	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

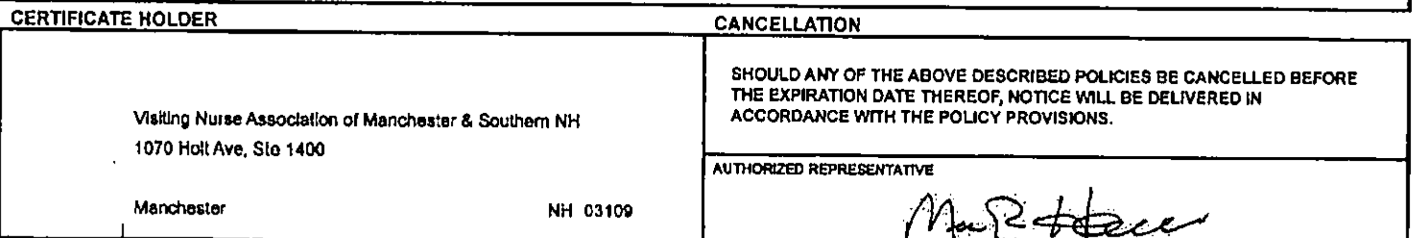
Bedford Nursing & Rehab Services LLC
DBA: Bedford Nursing & Rehabilitation Center
480 Donald St
Bedford NH 03110

COVERAGES CERTIFICATE NUMBER: 20-21 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; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC; OTHER:			602792490	10/01/2020	10/01/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
							Employee Benefits	$ 1,000,000
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB / OCCUR; X EXCESS LIAB / CLAIMS-MADE; DED / RETENTION $			UMB60727250	10/01/2020	10/01/2021	EACH OCCURRENCE	$ 5,000,000
							AGGREGATE	$ 5,000,000
								$
	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					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
B	D&O Liability & EPL			EKO3347628	10/10/2019	10/10/2020	D&O Per Claim	$2,000,000
							D&O Aggregate	$3,000,000
							EPL Aggregate	$2,000,000

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



CERTIFICATE HOLDER	CANCELLATION
Visiting Nurse Association of Manchester & Southern NH 1070 Holt Ave, Ste 1400 Manchester NH 03109	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

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DocuSign Envelope ID: 73E32CFD-08EA-4036-932F-C774ABC6C035

Granite State Healthcare
and Human Service Trust

PO Box 4197
Concord, NH 03302-4197

Issue Date 12/01/2020

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.

Certificate Of Insurance

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

Companies Affording Coverage

COMPANY LETTER A	The Granite State Healthcare And Human Services Self-Insured Group Trust
COMPANY LETTER B	Midwest Employers Casualty Corp.

This policy is effective on 2/1/2020 12:00 AM, and will expire on 2/1/2021 12:00 AM. This policy will automatically be renewed unless notified by either party by October 1st of any fund year.

COVERAGES

This is to certify that the Workers' Compensation and Employer's Liability Insurance has been issued to the insured named above for the policy period indicated, not withstanding 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.

Type of Insurance/Carrier	Policy Number	Policy Effective	Policy Expiration	LIMITS	
Workers' Compensation & Employer's Liability The Granite State Healthcare And Human Services Self-Insured Group Trust	HCHS20200000202	2/1/2020 12:00 AM	2/1/2021 12:00 AM	W/C Statutory Limits E.L. Each Accident E.L. Disease - Pol Limit E.L. Disease - Each Emp	 $1,000,000 $1,000,000 $1,000,000
Excess Insurance Midwest Employers Casualty Corp	EWC009477	2/1/2020 12:00 AM	2/1/2021 12:00 AM	Workers' Compensation Employer's Liability	Statutory $1,000,000

Description of Operations:

Covering operations of the insured during the policy term. Per NH Law, additional insured and waiver of subrogation are not allowed on workers' comp. COIs.

☒ Excluded Officer
John Turcotte

MEMBER

Bedford Nursing & Rehab Services, LLC
480 Donald Street
Bedford, NH 03110

CANCELLATION

Should any of the above described policies be canceled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the certificate holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

Authorized Representative	Date
	12/01/2020

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and BEL-AIR NURSING AND REHAB CENTER INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,916,100

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/23/2020
Date

DocuSigned by:
Lisa M. Morris
D938DBF8BCEB4A4...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

BEL-AIR NURSING AND REHAB CENTER INC

12/23/2020
Date

DocuSigned by:
Robert Lenox
AC34E23...
Name: Robert Lenox
Title: CEO

DocuSign Envelope ID: AB79BE28-FBB5-492F-A502-C925477E904D

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 42,100.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 421 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials RL

Date 12/23/2020

DocuSign Envelope ID: AB79BE28-FBB5-492F-A502-C925477E904D

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

RL

Date

12/23/2020

Business Information

Business Details

Business Name:	BEL-AIR NURSING AND REHAB CENTER, INC.	Business ID:	696435
Business Type:	Domestic Profit Corporation	Business Status:	Good Standing
Business Creation Date:	08/20/2013	Name in State of Incorporation:	Not Available
Date of Formation in Jurisdiction:	08/20/2013		
Principal Office Address:	560 Granite Lake Rd, Munsonville, NH, 03457, USA	Mailing Address:	NONE
Citizenship / State of Incorporation:	Domestic/New Hampshire		
		Last Annual Report Year:	2020
		Next Report Year:	2021
Duration:	Perpetual		
Business Email:	s.ellison@CLRM.com	Phone #:	603-621-7100
Notification Email:	NONE	Fiscal Year End Date:	NONE

Principal Purpose

S.No	NAICS Code	NAICS Subcode
1	OTHER / operate a residential care facility, including nursing home services and rehabilitation services	

Page 1 of 1, records 1 to 1 of 1

Principals Information

Name/Title	Business Address
Robert W. Lenox / President	560 Granite Lake Road, Munsonville, NH, 03457, USA
Robert W. Lenox / Treasurer	560 Granite Lake Road, Munsonville, NH, 03457, USA
Robert W. Lenox / Secretary	560 Granite Lake Road, Munsonville, NH, 03457, USA
Robert W. Lenox / Director	560 Granite Lake Road, Munsonville, NH, 03457, USA

Page 1 of 1, records 1 to 4 of 4

CERTIFICATE OF AUTHORITY

I, Bette J. Lenox, hereby certify that:

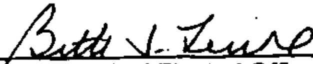
1. I am a duly elected Clerk/Secretary/Officer of Bel-Air Nursing & Rehab Center.

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 December 19, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Robert W. Lenox is duly authorized on behalf of Bel-Air Nursing & Rehab 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.

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: December 23, 2020



Signature of Elected Officer
Name: Bette J. Lenox
Title: Vice President

DocuSign Envelope ID: AB79BE28-FBB5-492F-A502-C925477E904D

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2020

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 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
THE ROWLEY AGENCY INC.
45 Constitution Avenue
P.O. Box 511
Concord NH 03302-0511

CONTACT NAME: Susan Gilman
PHONE (A/C, No, Ext): (603)224-2562 FAX (A/C, No): (603)224-8012
E-MAIL ADDRESS: sgilman@rowleyagency.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Submissions	
INSURER B: American Cas Co of Reading PA	20427
INSURER C: Columbia Casualty	
INSURER D: Granite State HC & HS	
INSURER E:	
INSURER F:	

INSURED
Bel-Air Nursing and Rehab Center, Inc.
29 Center Street

Goffstown NH 03045

COVERAGES CERTIFICATE NUMBER: 20-21 Cert 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			PLO6076054909	2/1/2020	2/1/2021	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR			Professional Liability			DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
				$1,000,000 Each Claim Limit			MED EXP (Any one person)	$ 5,000
				$3,000,000 Aggregate Limit			PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:			Policy Aggregate Limit of			GENERAL AGGREGATE	$ 3,000,000
	X POLICY PRO-JECT LOC			Insurance: $6,000,000			PRODUCTS - COMP/OP AGG	$ Included
	OTHER:							$
B	AUTOMOBILE LIABILITY			6076054943	2/1/2020	2/1/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
C	X UMBRELLA LIAB X OCCUR			6076054912	2/1/2020	2/1/2021	EACH OCCURRENCE	$ 1,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 1,000,000
	DED X RETENTION $ 10,000							$
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			HCHS20200000204	2/1/2020	2/1/2021	X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N	N/A		3A State: NH			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

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

CERTIFICATE HOLDER

FOR INFORMATIONAL PURPOSES ONLY

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
Susan Gilman/SJG Susan Gilman

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COLONIAL POPLIN NURSING HOME INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,937,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COLONIAL POPLIN NURSING HOME INC

12/17/2020
Date

DocuSigned by:
Gina Queiros
Name: Gina Queiros
Title: admn

DocuSign Envelope ID: 7219A7F9-FD61-4D6F-947D-C3D46C7A78E4

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 63,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 630 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials GQ
Date 12/17/2020

DocuSign Envelope ID: 7219A7F9-FD61-4D6F-947D-C3D46C7A78E4

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS GQ

Date

12/17/2020

DocuSign Envelope ID: 7219A7F9-FD61-4D6F-947D-C3D46C7A78E4

State of New Hampshire

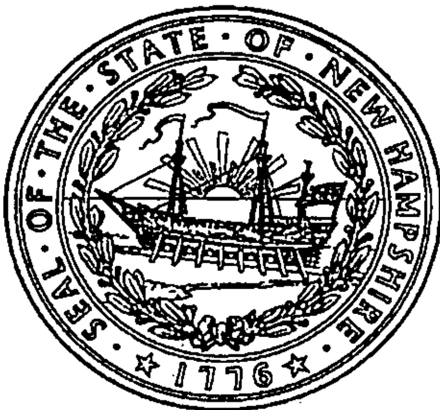
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that COLONIAL POPLIN NURSING HOME, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on June 18, 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: 251778

Certificate Number: 0005030717



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 20th day of October A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Jeffrey Philbrick, 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 Colonial Poplin Nursing Home, Inc.
(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 12/21/20, 20 20, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Gina Quieros (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Colonial Poplin Nursing Home 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: 12/21/20

Signature of Elected Officer
Name: Jeff Philbrick
Title: President

DocuSign Envelope ID: 7219A7F9-FD61-4D6F-947D-C3D46C7A78E4

COLOPOP-01 LJUKIC

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/21/2020

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: Anna Gallant, ACSR, CISR, CRIS	
People's United Insurance Agency, Inc. 1555 Lafayette Road Portsmouth, NH 03801	PHONE (A/C, No, Ext): (603) 427-7534 413	FAX (A/C, No): (844) 254-7670
	E-MAIL ADDRESS: Anna.Gallant@peoples.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Columbia Casualty Company	31127
INSURED Colonial Poplin Nursing Home, Inc. Poplin Way, Inc & Bittersweet Prop, LLC 442 Main Street Fremont, NH 03044	INSURER B : New Hampshire Employers Insurance	13083
	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 X CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY ☐ PRO-JECT ☐ LOC OTHER:			6049803248	7/1/2020	7/1/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ 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 Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040003442019A	1/22/2020	1/22/2021	X PER STATUTE ☐ OTH-ER	
							E.L. EACH ACCIDENT	$ 100,000
							E.L. DISEASE - EA EMPLOYEE	$ 100,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
A	Professional Liab			6049803248	7/1/2020	7/1/2021	$1,000,000 EA Claim	3,000,000

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

CERTIFICATE HOLDER	CANCELLATION
New Hampshire Department of Health and Human Services 129 Pleasant St Concord, NH 03301	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 *People's United Insurance Agency, Inc.*

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF BELKNAP ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,976,800

   Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

2. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
3. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/14/2021
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTY OF BELKNAP

1/14/2021
Date

DocuSigned by:
Debra Shackett
Name: Debra Shackett
Title: County Administrator

DocuSign Envelope ID: F9D391B6-0395-401F-810A-8FD29BFE7891

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $102,400.00__, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed _1024____ test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

   4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

   4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

   4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

      4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

      4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

      4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials DS
Date 1/14/2021

DocuSign Envelope ID: F9D391B6-0395-401F-810A-8FD29BFE7891

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
DS

Date

1/14/2021

CERTIFICATE OF AUTHORITY

I, David DeVoy, 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 Belknap County.
(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 December 03, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

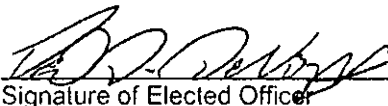
VOTED: That Debra Shackett (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Belknap County to enter into a contract or agreement with the State
(Name of Corporation/ LLC)

of New Hampshire DHHS 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:_12/16/2020



Signature of Elected Officer
Name: David DeVoy
Title: Commissioner, Chairman

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Belknap County 34 County Drive Laconia, NH 03246	607	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability** (Occurrence Form)	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence	1/1/2021	1/1/2022	General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
X	**Automobile Liability** Deductible Comp and Coll: $1,000 ☐ Any auto	1/1/2020 1/1/2021	1/1/2021 1/1/2022	Combined Single Limit (Each Accident)	$ 5,000,000
				Aggregate	$ 5,000,000
X	**Workers' Compensation & Employers' Liability**	1/1/2020 1/1/2021	1/1/2021 1/1/2022	X Statutory	$ 2,000,000
				Each Accident	$ 2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
X	**Property** (Special Risk includes Fire and Theft)	1/1/2020 1/1/2021	1/1/2021 1/1/2022	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: $1,000

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER:	☐ Additional Covered Party	☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
			By: *Mary Beth Purcell*
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301			Date: 12/16/2020 mpurcell@nhprimex.org
			Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF CARROLL ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,007,700

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

1/13/21

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

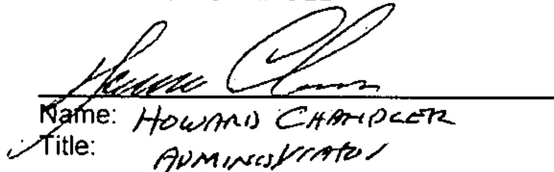
State of New Hampshire
Department of Health and Human Services

01/14/2021
Date

Name: Lisa Morris
Title: Director

COUNTY OF CARROLL

1/13/2021
Date



Name: HOWARD CHANDLER
Title: ADMINISTRATOR

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $133,300.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,333 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

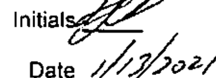
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials 

Date 1/13/2021

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

Date

Initial [signature] Date 1/14/2021

CERTIFICATE OF AUTHORITY

We, ~~I~~, Carroll County Board of Commissioners, 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 Carroll County

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 13, 2021, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Howard Chandler, Administrator or Paula Coates, Director of Finance (may list more than one person) is duly authorized on behalf of Carroll County 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: 01/13/2021

Terry McCarthy
Signature of Elected Officer
Name: Terry McCarthy
Title: Chair Board of Commissioners

Commissioner Kimberly Tessari

Commissioner Matthew Plache

Rev. 03/24/20

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Carroll County 95 Water Village Road Ossipee, NH 03864	600	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability** (Occurrence Form)	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence	1/1/2021	1/1/2022	General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
X	**Automobile Liability** Deductible Comp and Coll: $1,000 ☐ Any auto	1/1/2020 1/1/2021	1/1/2021 1/1/2022	Combined Single Limit (Each Accident)	$ 5,000,000
				Aggregate	$ 5,000,000
X	**Workers' Compensation & Employers' Liability**	1/1/2020	1/1/2021	X Statutory	$ 2,000,000
		1/1/2021	1/1/2022	Each Accident	$ 2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
X	**Property** (Special Risk includes Fire and Theft)	1/1/2020 1/1/2021	1/1/2021 1/1/2022	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: $1,000

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER:		**Additional Covered Party**		**Loss Payee**	**Primex³ – NH Public Risk Management Exchange**
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301					**By:** *Mary Beth Purcell* **Date:** 12/8/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF CHESHIRE ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,079,600

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTRY OF CHESHIRE

12/18/2020
Date

DocuSigned by:
Kathryn Kindopp
Name: Kathryn Kindopp
Title: Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $205,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 2052 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials kk
Date 12/18/2020

DocuSign Envelope ID: 76AC7175-5F1E-42E9-A25B-4FA8648DD612

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

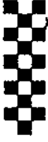
Name

Title

DS kk

Date

12/18/2020



CERTIFICATE OF AUTHORITY

I, _____Robert Englund_________________________, 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 Cheshire County Board of Commissioners___________.
(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 December 30, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Kathryn Kindopp, Cheshire County Maplewood Nursing Home Administrator
(Name and Title of Contract Signatory)

is duly authorized on behalf of Cheshire County 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:_12/30/20_

Robert Englund
Signature of Elected Officer
Name: Robert Englund
Title: Clerk of the Board of Commissioners

DocuSign Envelope ID: 76AC7175-5F1E-42E9-A25B-4FA8648DD612

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Cheshire County 12 Court Street 1st Floor - Room 171 Keene, NH 03431	601	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Limits - NH Statutory Limits May Apply, If Not:	
X	General Liability (Occurrence Form)	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
	Automobile Liability Deductible Comp and Coll: ☐ Any auto			Combined Single Limit (Each Accident)	
				Aggregate	
X	Workers' Compensation & Employers' Liability	1/1/2020	1/1/2021	X Statutory	$2,000,000
				Each Accident	$2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
	Property (Special Risk includes Fire and Theft)			Blanket Limit, Replacement Cost (unless otherwise stated)	

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
	By: *Mary Beth Purcell*
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	Date: 10/21/2020 mpurcell@nhprimex.org Please direct inquires to: Primex³ Claims/Coverage Services 603-225-2841 phone 603-228-3833 fax

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF COOS ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,012,200.00

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/23/2020
Date

DocuSigned by:
Lisa M. Morris
D938DE46C6A54...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTY OF COOS

12/23/2020
Date

DocuSigned by:
Lynn M. Beede
72F0F026...
Name: Lynn M. Beede
Title: NHA

DocuSign Envelope ID: 4DBE294A-3E39-412A-A667-B486C4A90A70

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $137,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,378 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials LB
Date 12/23/2020

DocuSign Envelope ID: 4DBE294A-3E39-412A-A667-B486C4A90A70

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
LB

Date

12/23/2020

Coös County Commissioners' Office
P.O. Box 10
West Stewartstown, N.H. 03597
603-246-3321
fax: 603-246-8117

CERTIFICATE OF AUTHORITY

I, Rick Samson, Clerk of New Hampshire Coös County Board of Commissioners, 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 Coös County, New Hampshire, Board of Commissioners.
(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 October 13, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Lynn M. Beede, MSN, RN Nursing Home Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Coös County, Nursing Home 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: Dec 29, 2020

Richard Samson
Richard Samson (Dec 29, 2020 10:35 EST)

Signature of Elected Officer
Name:
Title:

COMMISSIONERS

Rev. 03/24/20 [THOM]AS M. BRADY, Jefferson • PAUL R. GRENIER, Berlin • RICK SAMSON, Stewartstown

DocuSign Envelope ID: 4DBE294A-3E39-412A-A667-B486C4A90A70

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Coos County PO Box 10 West Stewartstown, NH 03597	602	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	General Liability (Occurrence Form)	7/1/2020	7/1/2021	Each Occurrence	$ 5,000,000
x	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
X	Automobile Liability Deductible Comp and Coll: $1,000 ☐ Any auto	7/1/2020	7/1/2021	Combined Single Limit (Each Accident)	$5,000,000
				Aggregate	$5,000,000
X	Workers' Compensation & Employers' Liability	1/1/2020	1/1/2021	X Statutory	
				Each Accident	$2,000,000
				Disease – Each Employee	$2,000,000
				Disease – Policy Limit	
X	Property (Special Risk includes Fire and Theft)	7/1/2020	7/1/2021	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: $1,000

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
	By: *Mary Beth Purcell*
Coos County PO Box 10 West Stewartstown, NH 03597	Date: 11/4/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF COOS ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,012,200.00

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by: Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTY OF COOS

12/18/2020
Date

DocuSigned by: Laura Mills
Name: Laura Mills
Title: Nursing Home Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $137,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,378 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

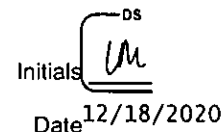
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.



Initials

Date 12/18/2020

DocuSign Envelope ID: 954C6749-8ED2-46B4-9B11-AB28A2A62D37

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
LM

Date

12/18/2020

DocuSign Envelope ID: 954C6749-8ED2-46B4-9B11-AB28A2A62D37

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Coos County PO Box 10 West Stewartstown, NH 03597	602	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability** (Occurrence Form)	7/1/2020	7/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
X	**Automobile Liability** Deductible Comp and Coll: $1,000 ☐ Any auto	7/1/2020	7/1/2021	Combined Single Limit (Each Accident)	$5,000,000
				Aggregate	$5,000,000
X	**Workers' Compensation & Employers' Liability**	1/1/2020	1/1/2021	X Statutory	
				Each Accident	$2,000,000
				Disease – Each Employee	$2,000,000
				Disease – Policy Limit	
X	**Property** (Special Risk includes Fire and Theft)	7/1/2020	7/1/2021	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: $1,000

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
DHHS, State of NH 129 Pleasant Street Concord NH 03301	By: *Mary Beth Purcell* Date: 11/6/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

Coös County Commissioners' Office
P.O. Box 10
West Stewartstown, N.H. 03597
603-246-3321
fax: 603-246-8117

CERTIFICATE OF AUTHORITY

I, Rick Samson, 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.
(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 October 13, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Laura Mills, Nursing Home Administrator of Coos County Institution DBA Coos County Nursing Hospital (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of COOS COUNTY 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: Dec 29, 2020

Richard Samson
Signature of Elected Officer
Name: Rick Samson
Title: Coos County, Clerk

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF GRAFTON ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,034,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/22/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTRY OF GRAFTON

12/21/2020
Date

DocuSigned by:
Craig J. Labore
Name: Craig Labore
Title: administrator

DocuSign Envelope ID: E9673E73-B947-4F99-AA20-E1006B5BBFA8

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $160,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,600 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

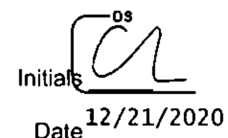
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.



Initials

Date 12/21/2020

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New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS

Date

12/21/2020

CERTIFICATE OF AUTHORITY

I, Marcia Morris, Clerk of the Commissioners, do hereby certify that:

1. I am a duly elected Clerk of the County of Grafton.

2. The following is a true copy of a vote taken at a meeting of the Commissioners of the County of Grafton duly held on December 22, 2020:

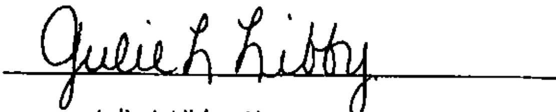
VOTED: That Craig J. Labore, Grafton County Nursing Home Administrator is duly authorized on behalf of Grafton County to enter into contracts and agreements with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgement 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 County. To the extent that there are any limits on the authority of the listed individual to bind the County in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

(Clerk of the Commissioners, Marcia Morris)

STATE OF NEW HAMPSHIRE
County of Grafton

The forgoing instrument was acknowledged before me this 22nd day of December, 2020 by Marcia Morris.



Julie L Libby, Notary

(NOTARY SEAL)

Commission Expires: ______________

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Grafton County 3855 Dartmouth College Highway Box #1 North Haverhill, NH 03774	603	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability (Occurrence Form)**	7/1/2020	7/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe)			General Aggregate	$ 5,000,000
	☐ Claims Made ☐ Occurrence			Fire Damage (Any one fire)	
				Med Exp (Any one person)	
	Automobile Liability Deductible Comp and Coll: ☐ Any auto			Combined Single Limit (Each Accident) Aggregate	
X	**Workers' Compensation & Employers' Liability**	7/1/2020	7/1/2021	X Statutory	$2,000,000
				Each Accident	$2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
	Property (Special Risk includes Fire and Theft)			Blanket Limit, Replacement Cost (unless otherwise stated)	

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ **Additional Covered Party** ☐ **Loss Payee**	**Primex³ – NH Public Risk Management Exchange**
	By: *Mary Beth Purcell*
State of NH, Department of Health and Human Services 129 Pleasant St Concord, NH 03301	**Date:** 10/20/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF MERRIMACK ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,324,100

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTY OF MERRIMACK

12/18/2020
Date

DocuSigned by:
Patrick Robinson
Name: Patrick Robinson
Title: Infection Prevention

DocuSign Envelope ID: C72EB4E3-8FB9-4274-BE02-81FF0B13D655

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $449,700.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 4,497 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials PR

Date 12/18/2020

DocuSign Envelope ID: C72EB4E3-8FB9-4274-BE02-81FF0B13D655

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS PR

Date

12/18/2020

CERTIFICATE OF AUTHORITY

I, Matthew Lagos, 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 County of Merrimack Dba Merrimack County Nursing Home
(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 9-29, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

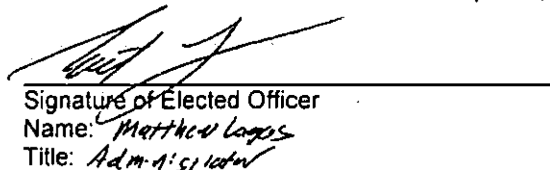
VOTED: That Patricy Robinson, RN (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of County of Merrimack 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: 12-18-20



Signature of Elected Officer
Name: Matthew Lagos
Title: Administrator

Rev. 03/24/20

DocuSign Envelope ID: C72EB4E3-8FB9-4274-BE02-81FF0B13D655

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex^3) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex^3 is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex^3 is entitled to the categories of coverage set forth below. In addition, Primex^3 may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex^3, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex^3 Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex^3. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Merrimack County 333 Daniel Webster Highway Suite 2 Boscawen, NH 03303	604	NH Public Risk Management Exchange - Primex^3 Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability (Occurrence Form)**	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe)			General Aggregate	$ 5,000,000
	☐ Claims Made ☐ Occurrence			Fire Damage (Any one fire)	
				Med Exp (Any one person)	
	Automobile Liability Deductible Comp and Coll: ☐ Any auto			Combined Single Limit (Each Accident)	
				Aggregate	
X	**Workers' Compensation & Employers' Liability**	1/1/2020	1/1/2021	X Statutory	$2,000,000
				Each Accident	$2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
	Property (Special Risk includes Fire and Theft)			Blanket Limit, Replacement Cost (unless otherwise stated)	

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex^3 – NH Public Risk Management Exchange
	By: *Mary Beth Purcell*
State of NH DHHS 129 Pleasant St Concord, NH 03301	Date: 10/27/2020 mpurcell@nhprimex.org
	Please direct inquires to: **Primex^3 Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and COUNTY OF SULLIVAN ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,015,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by: Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

COUNTRY OF SULLIVAN

12/18/2020
Date

DocuSigned by: Ted J. Purdy
Name: Ted J. Purdy
Title: Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $140,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,408 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials JGP

Date 12/18/2020

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New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
JJP

Date

12/18/2020

CERTIFICATE OF AUTHORITY

I, **Joe Osgood,** 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 **Sullivan County Commissioners**.
(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 25, 2021** at which a quorum of the Directors/shareholders were present and voting.
(Date)

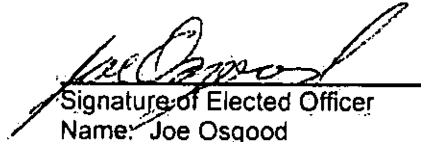
VOTED: That **Ted J. Purdy, Administrator** (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of **Sullivan County Commissioners** 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: 1/25/2021



Signature of Elected Officer
Name: Joe Osgood
Title: Clerk, Sullivan County Commissioners

Sullivan County, NH
Board of Commissioners
Monday, January 25, 2021, 3:00 PM
Regular Business Meeting Minutes - DRAFT
Meeting was open to public via Zoom Webinar ID: 927 7922 0636 | T. 1-312-626-6799
Physical location of meeting: 14 Main Street, Newport, NH, 03773 – Probate Court Room

Attendees at physical location: Commissioners George Hebert, *Chair*, Bennie Nelson, *Vice Chair* and Joe Osgood, *Clerk*; Rep. Judy Aron, *District 7 Delegate*; and Derek Ferland, *County Manager*.

Zoom attendees: Sara Rouillard, *Facilities & Operations Administrative Assistant*; Hilary Snide, *Human Resources Director*; Mary Bourque, *Facilities & Operations Director*; Supt. David Berry, *Department of Corrections*; Ted Purdy, *Sullivan County Health Care Administrator*; Delegation Rep's Terry Spilsbury, *District 8 (R)*, and Walt Stapleton, *District 5 Ward 3 Claremont (R)*; Dodi Violette, *Commissioners Office/Financial Account Clerk I*; and Sharon Callum, *Commissioners Office Admin. Assist./Minute Taker (Commissioners Office 1st Floor).*

Chair George Hebert brought the meeting to order at **3:30 p.m.**

1. **County COVID-19 Update, Derek Ferland, County Manager**: County Manager (CM) Derek Ferland updated the COVID19 outbreak numbers in the Sullivan County Health Care (SCHC) building and at the jail. Ted Purdy, SCHC Administrator reported that as of 1/22/2021 49 residents tested positive and 12 new cases brought the running total of resident cases to 61 as of today; additionally, the running total of staff positives is now 34 staff but 15 of these have recovered and are back at work. Purdy confirmed that of those testing positive on SCHC Stearns 3 many are making improvements and are in their second week and those in the new Stearns 1 and Stearns 2 exhibited none or slight symptoms, some with coughs and chills. Next vaccination date is Wed. Jan. 27 for those doing well and making improvements with the following scheduled date three weeks out. Ten to fifteen of the staff who did not take the vaccine on the first round have confirmed they'll be taking it this week. DOC Supt. Berry reported that they had 1 employee who tested positive yesterday, 9 today, and three 3 Saturday and of the 7 who tested positive a week ago, 1 is dropping off the list tomorrow; accordingly, they'll have 18 active cases tomorrow with most symptoms being runny noses with no fevers. DOC is scheduled to receive 30 vaccine vials Feb. 10th 2:00 p.m., nurses there have already received their vaccines and they'll be vaccinating one (1) clinician and (1) administration staff, as well. Purdy confirmed that their new Nurse Practitioner is reviewing all eligible for vaccination to ensure they can get their second dosage.

2. **Facilities & Operations, *Mary Bourque, Director***
   a. <u>January 2021 Facilities & Operations Department Report</u>: Director Mary Bourque (MB) reported that January was a tough month for them as they performed winter maintenance, chased heating issues, dealt with complications of the COVID19 restrictions and limitation of staff on floors; doing all while prioritizing urgent work vs. work that can wait until the pandemic passes. She highlighted on the new *Helpful Hints* resource they've provided to

staff; a copy was viewed by the BOC (See Footnote[1]). Central Supply Update: they continue to work with NH State for PPE, which is delivered on a weekly basis by the National Guard; Amanda does a great job tracking PPE and has met with the new Nurse Practitioner for items to prescribe, eliminating other items or consolidating lines of products with redundant vendors. They are almost finished with the new med and treatment rooms. Completed projects: Denron replaced the heat pump in the Newport complex foyer.

b. Biomass Annual Public Utilities Commission (PUC) Report (See Footnote[1]): MB explained that as a result of receiving a grant to help build the biomass facility, she reports [to PUC], annually, data related to its operations and conducted outreach. She briefed all on the data, which included a $106,143 cost savings based on the cost difference of woodchips vs. #2 fuel oil. MB pointed out that the report illustrates 1,641 Thermal RECs produced but should say "6,565". She added that they typically provide tours and presentations throughout the year, a stipulation of receiving the grant, but were unable to hold these due to the pandemic, however, the PUC report included a news article about the condensate repair project. Chair Hebert asked what the term was for the supply chip contract. MB noted during the meeting she believed it was for 2-years, but would check. [After the meeting, she confirmed that the wood chip fuel contract with Cousineau Forest Products is a 2-year term covering FY21 and FY22 that included an option for a third year (FY23; to be exercised by 2/28/2022]

c. Biomass T-REC Sales Contract Renew; Motion Required: A summary of the *Thermal Renewable Energy Credits CY2021-CY2022 Purchase Proposal Summary* was viewed by all (SeeFootnote1). The recommendation is to stay with Wilson Energy & Environment (WE&E) based on the "*Advantages/Additional Services*" that MB reviewed on the summary document; added advantages more than covers the $1,400 less difference from others. MB pointed out that for Q3 WE&E sold RECs at $25.55/REC. She confirmed she did a comparison to last year and that #'s will decrease next year as they'll burn less chips; but this is good news because it means we are burning fewer chips and therefore spending less on chips. MB confirmed that Froling Energy's net price is without all the fees. She confirmed self-managing (finding people to buy RECs) would involve making and fielding phone calls; and most inquiries received over the last 12-months average a value of 85% of the ACR ((Alternative Compliance Rate that utilities pay to state (penalty) for not producing or purchasing offsets (T-RECs) for their allocated renewable energy quote)) MB confirmed Froling would charge additional for the extra items WE&E is already providing.

Nelson moved, and Osgood seconded, a motion at 3:53 p.m. in accordance with Purchasing Policy Section 2.1.1, to approve a limited competition waiver for the procurement of services to market and sell thermal renewable energy credits generated by the County and authorize the Director of Facilities and Operations to execute a contract with WES (Wilson Engineering Services) Energy & Environment, LLC of Meadville, PA for a 7.5% commission rate for all credits generated through

[1] All documents not in draft or confidential format can be found at www.sullivancountynh.gov website by selecting Budgets, Minutes & Annual Reports; Commissioners Meeting Agenda and Minutes; the folder for the calendar year of the date of the meeting; then the appropriate meeting date. Call 603-863-2560 with any questions.

December 31, 2022. A roll call vote was taken, with all three Commissioners voting 'Yes'. The motion carried, unanimously.

3. **Department of Corrections, *David Berry, Superintendent***
   a. December 2020/January 2021 Report (See Footnote1): Supt. Berry reported that they continue to work on the MAT (Medication-assisted Treatment] policy as they now have two providers and he anticipates the BOC reviewing this at their second meeting in February; they are waiting for the upload of XJail onto the clinical computers; they are drafting a training manual for FTO's to use for new hires; there were no major incidents to report; as far as staffing, one Correctional Officer (CO) and a Corporal resigned so they now have eight (8) CO and two (2) Corporal vacancies; they currently have six (6) males and two (2) females in treatment; programing continues for the female population and they suspended it for males, due to COVID; one (1) male inmate returned from the State hospital to finish their sentence; they are waiting for a RedHawk quote to update camera/video equipment as the switch-over is not working; they continue to see heating issues in the male flex unit; most events/meetings listed in the report relate to department head Zoom meetings; he attended a successful VINE presentation for the Rockingham BOC (via Zoom), as they were considering not funding the program and as a result they decided to fund it; the NHAC job description was completed and posted and they are working on the NH Police Standards lesson plan that NHAC Corrections Affiliate teaches related to *understanding what county corrections does*; two (2) male inmates and one (1) female graduated from the TRAILS 90-day program, while one (1) male graduated from the 12-month *Aftercare* program; due to COVID, outside agencies have moved to holding Zoom classes; the *NHAC 114th Academy* is being reschedule to April; CERT training was canceled; and two (2) FTO's completed their training. Over the time period, they recorded 115 nurse visits for medial issues; 26 VRH physician in house visits; and 177 Covid tests conducted. Investigations this period included: a one-on-one between inmates where no one pressed charges and was dismissed; a possible PREA incident that was unfounded; assisting the County Attorney on phone calls for three (3) offenders and with an ongoing introduction of contraband case related to two (2) females. The VINE digital ad outreach campaign has been successful, and they had 6,302 hits in January!

4. **Human Resources, *Hilary Snide, Director***: All viewed the December 2020/January 2021 Report (See Footnote[1]): HR Director Hilary Snide reported that they are wrapping up the Long-Term Care (LTC) stabilization payments with (2) more to go! W2 forms were distributed to employees 1/22/2021. They are performing off sight new employee orientations. *(At this point, Snide's internet failed and she rejoined the Zoom BOC meeting at 4:11)* She reported they are all working on end of year processes and though ACA was reconciled, they are waiting for the forms to print it on. Open enrollment for benefit plans will be rolled out in March, with further conversations to take place in May, as plans become effective July 1st. Monica Lizotte spear headed a county wide Wellness Challenge based on volume of steps and they are seeing good participation! As mental health has been a predominant discussion among all HR reps, Sullivan is researching Colonial Life Insurance's coverage (3rd party) to learn more; meanwhile, they continue to support staff through the HealthTrust EAP. NACo Leadership Training continues with April Bartley, Shawn Coughlin, Lionel Chute and Ms.

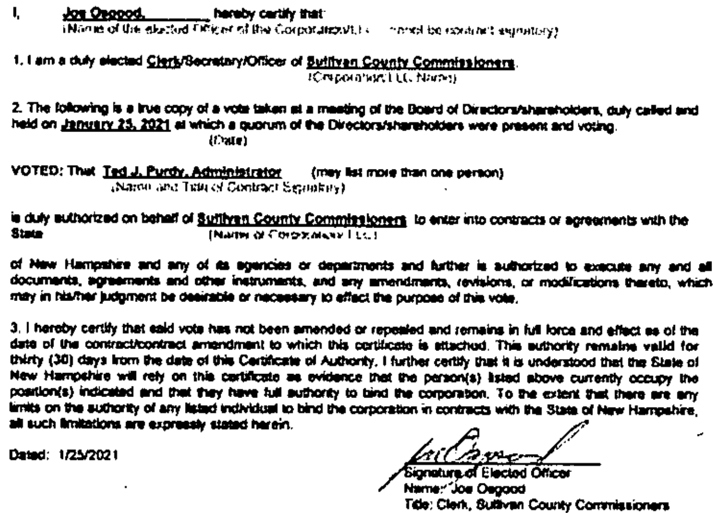
Snide; this program entails two meetings a week and 6-7 hours of additional time. HR is also prepping for the FY22 budget season and helping the County Manager with reviews of policies.

5. **Natural Resources, *Lionel Chute, Director*:** Director Lionel Chute (LC) reported that the Conservation District is in good shape and that Dawn Dextraze produced a glossy annual report booklet that should boost the District image; this report has not been published in 15-20 years and its circulation, soon, is expected to reach more people!

   On the Natural Resources side Chute discussed the taxation on County property by the Town of Unity; briefly mentioning the back-and-forth that occurred last year with the town regarding lessees of specific farm land parcels and how it was resolved with the town withdrawing the duplicate tax payment request (to lessees); and, the town's letter of 12/16/2020 requesting that the County complete a form identifying what parcels they are claiming tax exemptions on and to submit that list within 15-days. CM Ferland requested an extension for their response to allow time to figure out the best route to go. Chute has researched the property taxes paid in previous years; plus, revisited the NH State RSA's around leasing, and ascertained that *government use of lands is automatically exempt from taxation* but county *'farm usage' is not*. He feels they've overpaid taxes on the nursing home and jail, which are clearly government functions, for years by about $8,016/year (2020 payment) and feels it should be more around $3,000. He feels the BOC should decide whether to continue overpaying taxes or make the appropriate property exemptions to pay less; for example, exempting properties like the parcel the NH State DOT salt shed is located on; the shooting range [used for firing arm recertification] area; all properties with buildings; and, possibly, ones they keep open for public use as hunting, hiking, snowmobiling, educational functions, and for the Boy Scouts. Osgood pointed out that the Marshall Pond parcel is used to provide water for the fire pond that provides fire protection for the Unity complex buildings. CM mentioned this will likely result in a discussion between BOC and Unity select board because any change from the current $18K in taxes the County pays each year will be noticeable. According to the RSAs, the County should probably only pay about $3K per year. CM said it doesn't make sense for the County to overpay Unity and it's not fair to the other County taxpayers. Furthermore, in the past the town's select board has not necessarily treated the County particularly well—the condition of County Farm Road is a glaring example of the fact that the County has not received much from the town in exchange for its generous tax payment. A brief discussion commenced between BOC members related to the interpretation of *'farmland'*. At the BOC request, CM and Chute will continue working on this project and return to the BOC with a summary of properties and their uses for consideration to include on the exemption form. BOC reviewed trespassing memos from the County Manager to two Unity parcel abutters: 1) involves illegal campsite, a trail to it, and signs that the abutters have been placing on County property – County has been in communication with the trespassers, and 2) abutters who cut a 2/3 mile long ATV trail for joy riding that spills out into the hiking trail; maps and pictures will accompany the letters and be delivered certified and registered – they've already received a signature receipt from one of the recipients. LC and CM will deconstruct the trails and keep a better eye on the two areas and consider other strategies to cease activity. They are researching cell based wireless game cams that run approximately $400/each; they'll check signal strength in those locations and consider purchasing so that any motion activating the cameras would take pictures and transmit them immediately. LC confirmed trespassers have

chopped and shot into trees, abandoned tents, and that the County cleaned up the sites and returned to find them constructed again; either they don't realize they are on County land or don't care and they hope the letters will provide clarity about the boundaries and foster future respect. LC pointed out that the County has a standing policy related to having no fire or camping on lands without possible permission.

6. **Sullivan County Health Care, *Ted Purdy, Administrator***
   a. NH DHHS Requires Updated Certificate of Authority Ratified by BOC Clerk, for the Amended Hospital-based LTC Facility COVID19 Testing Program contract signed by Mr. Purdy 12/18/2020. All viewed the Certificate of Authority (Footnote[1]). Mr. Purdy noted this was a required authorization retroactive to the contract signed by him 12/18/20.
   Nelson moved, Osgood seconded, a motion at 4:10 pm to authorize the Board of Commissioners Clerk to enter into the minutes the Certificate of Authority that authorizes Ted Purdy, Sullivan County Health Care long term care facility Administrator to ratify the NH DHHS Amended Hospital-based LTC Facility COVID19 Testing agreement [retroactive to signing the amended agreement 12/18/2020]. A roll call vote was taken. All in favor. *(.jpg below of ratified Certificate of Authority reviewed and approved)*



CERTIFICATE OF AUTHORITY

I, Joe Osgood, 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 Sullivan County Commissioners.
(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 25, 2021 at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Ted J. Purdy, Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Sullivan County Commissioners 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: 1/25/2021

Signature of Elected Officer
Name: Joe Osgood
Title: Clerk, Sullivan County Commissioners

Rev. 03/24/20

b. December 2020/January 2021 Reports (See Footnote[1]): SCHC Administrator Ted Purdy reviewed the December 2020 reports, pointing out that the average daily census was 130, they saw a Medicare negative variance of $56,135; a Private pay positive variance of $41,830; a $21,325 Medicaid revenue variance; and additional Managed Care positive variance of $13,105; and, ended the month with a $3,068 positive variance. The *FY21 Revenue Review through 12/31/2020* report (lower left box) reflects the additional Medicaid payments of $220K and MQIP bed tax of $544,508. The *Medicare Length of Stay* report illustrates three (3) Admits & Readmits with an average total MCR LOS of 34 days. The *Quarterly Resident Census* report second quarter illustrates 132 average census and 130 total year-to-date. Due to Covid19 issues they've been unable to accept new admissions therefore the daily census has decreased and is averaging 125. Purdy noted that during a COVID outbreak the requirement for the 3-day hospital stay for Medicare Part A services is waived. The average Med A census for January was eight (8) Skilled and two (2) replacement plan Medicare skilled for total of 10 eligible for skilled services.

The *Summary Admission/Discharge Report* illustrates 3 Admissions/Readmits and 6 Discharges; with 46 Admissions/Readmits and 47 Discharges year-to-date. The *Month-End Aged Analysis Summary* report reflects a total of $2.077Million, which is $128K less than December 2020; reflective of the Business Office's diligent work!

7. **County Manager's Report, *Derek Ferland***
   a. Employee 'Shoutout': County Manager (CM) Ferland noted that the SCHC nursing staff wanted to recognize **Amanda Tomasko of Central Supply** as she's been wonderful throughout the pandemic coming in afterhours and weekends to ensure staff – especially nursing – has the needed PPE: masks, gloves, face shields, and gowns – much appreciated!

   b. Annual review of repetitive purchases (RSA 28:8): CM Ferland noted this is being deferred to next week; and feels this should be a discussion for the NHAC Legislative Strategy Committee to review and revise, as he feels it is antiquated and makes no sense as the RSA 28:8 was written for each vendor and for $5,000 limit - more to come!

   c. COVID-19 Sullivan Strong Community Assistance Update: All viewed the report (See Footnote[1]). CM Ferland noted that there is $50,293 remaining to use and that the reports detail all organizations that have received this funding, to date.

   d. Sullivan County Health Care Renovation Project Update: CM Ferland provided a print of the NH Municipal Bond Bank January interest rates bonds with 'unbelievable' interest rates for long term bonds [1.76% on 25-year bond]. He feels it would behoove the County to act quickly as he anticipates these rates increasing in a couple years. Hebert expressed hope that the Delegation members would consider cost options and understand them. Nelson requested CM Ferland include in his Delegation presentation how much per $1,000. Osgood requested he also include the cost to dismantle buildings that are not marketable and considered 'eye sores', based on today's prices by square foot.

   e. Sober Housing Project Update: CM Ferland reported that: the interior sand blasting on 19 Sullivan Street sober housing building is close to completion and once done he'll schedule a walk-through for Board members interested in viewing it; outside sewer and water connection work was been deferred to spring, however, they can address water connection aspects at the building foundation; NHH Board is meeting 1/28/20; that he's rethinking the Community Loan Fund aspect – a traditional debt - as, based the newest info, they may want to borrow from the NH Bond Bank which could save them $1,000/month - they would need to convene the Delegation for a public hearing on this aspect. CM Ferland provided a briefing on the unsuccessful BDAS grant application and follow up messages back and forth about RSA's, timelines, how many applications received; monies that were available; how the request for info was presented to Sullivan and his response, and the feeling they may have misunderstood how much was actually needed of funding from them, and his last follow up. CM Ferland reported that PUC issued another funding opportunity that he's preparing to present at their February meeting – he'll reuse info supplied in their previous roof solar array system application.

f. NH Association of Counties Updates. CM Ferland pointed out that the BOC received a print of a Primex flyer regarding the virtual conference date.

   i. State-County Finance Committee Update: Mr. Purdy confirmed that they continue to meet, strategize, and prepare for their next meeting; where they'll present to the Commission about FMAP monies retained by the State and how it gets back to the counties.

   ii. Legislative Items Update: CM Ferland noted that the BOC received a printed list of legislation that the NHAC is tracking, plus would have received this electronically with active blue font hyperlink to draft text. Chair Hebert confirmed email receipt. NHAC did a quality check of all, vectored out some to each affiliate for further consideration to prepare for the February Executive meeting and continue weekly meetings. NHAC is tracking a bill that relates to killing thermal RECs, which affects four counites who have biomass plants.

   iii. Strategy Committee: Nothing reported in this section.

g. Regional Economic Profile (REP) Project

   i. Economic Infrastructure Task Force: CM Ferland and Penelope Whitman are working with the regional planning commission on a CEDS (Comprehensive Economic Development Strategy) document; this is vital to update, otherwise it negatively impacts some that apply for grants and the CEDS will include the building blocks from the UNH community REP efforts. He and Whitman attended USDA workshops. CM attended NH CDFA HUD Tax Credit program application info [Zoom webinar].

   ii. Workforce Development Task Force: CM noted an article about the adult education class was placed in the BOC meeting binders for review.

   iii. Quality of Life Task Force: No updates at this time.

h. HUD Lead Abatement Grant Project Update: CM Ferland shared copies of a draft letter to be sent with businesses related to *Selling Tax Credits for Sullivan County's Lead Paint Abatement and Healthy Homes Programs* along with a draft flyer for "*Sullivan County is Getting the Lead Out to Prevent Childhood Lead Poisoning*". Chair Hebert requested a simple summary of the Tax Credit program that he can use as he reaches out to businesses for when he is seeking their support. CM will attain that info.

8. Board of Commissioner Business, *Bennie Nelson-Chair, George Hebert, Vice Chair and Joe Osgood, Clerk*

a. Old Business: nothing reported.

b. New Business

   i. Sullivan County HUD Grant Program Policies: Lead Paint Abatement & Healthy Homes Policy; Motion Required: CM noted this is two parts; an overarching policy; and Kate as Program Manager has indicated what is being done and how. (Tabled)

ii. Authority to Submit a NH CDFA Tax Credit Program Application in the amount up to $500,000: CM Ferland reported that they expect to apply for between $100K-$250K and it will depend on response received from business. BOC requested more information before completing the formal authorization. (Tabled)

iii. Authority to apply for New Hampshire Public Utilities Commission grant, RFP # 2021-004 LMI Community Solar; Motion Required.
Nelson moved, and Osgood seconded, a motion at 5:01 p.m. to authorize the County Manager to apply to NH Public Utilities Commission for a grant RFP#2021-004 LMI Community Solar roof top system for the sober housing project. A roll call vote was taken, with all three Commissioners voting 'Yes'. The motion carried, unanimously.

iv. Authority to accept a CHI/NH DHHS $36,500 Grant and for the County Manager to Sign Further Documents Associated with it: CM explained that CHI money will help pay for training in contractor capacity and as funds are set to expire NH DHHS and CHI decided to send the full amount to Sullivan County as a grant (not here yet), which is considered as match in the HUD Lead Abatement grant project; this way, the County will have full control of how and when to pay out the monies.
Nelson moved, and Osgood seconded, a motion at 5:04 p.m. to accept a Community Health Institute (CHI)/NH DHHS $36,500 grant and for the County Manager to sign further documents associated with the grant agreement that will provide match to the HUD Lead Abatement & Healthy Homes Program, and funding to increase #'s of lead abatement supervisors, workers and RRP (Renovation, Repair & Painting) contractors to be trained. All three Commissioners voted 'Yes' in favor of the motion. The motion carried, unanimously.

v. Mon. Feb. 15 BOC Meeting Requires Date Change (Holiday): Ms. Callum mentioned that Rep. Merchant needs to know the dates for both February BOC meetings in order to set their [Doodle Poll] dates for the next EFC meeting. The BOC members concurred in changing Mon. Feb. 15th to Tue. Feb. 16th. CM Ferland will connect with Rep. Merchant tomorrow.

9. Public Participation: There was no public participation at this time.

10. Draft Meeting Minutes Review

a. FY21 BOC/EFC Budget Review Work Sessions: Not in typed format.

b. Mon. Sep. 21, 2020 12Noon Strategic Planning Work Session: Not in typed format.

c. Mon. Oct. 5, 2020 Public Meeting Minutes: Not in typed format.

d. Mon. Oct. 19, 2020 Non-public Session Per RSA 91-A.3.II.(a): Not in typed format.

e. Mon. Dec. 7, 2020 Public Meeting Minutes: **Nelson moved, and Osgood seconded, a motion at 5:09 p.m. to accept the Mon. Dec. 7, 2020 Public Meeting Minutes as printed. Comm. Osgood recused himself from the vote. Commissioners Hebert and Nelson voted 'Yes.' in favor of the motion. The motion carried, with the majority.**

f. Wed. Jan. 6, 2021 Public Meeting Minutes: **Nelson moved, and Osgood seconded, a motion at 5:10 p.m. to approve the Wed. Jan. 6, 2021 meeting minutes as printed. All three Commissioners voted 'Yes'. The motion carried, unanimously.**

CM Ferland requested they adjourn to a non-meeting with County Attorney first, then return to conduct the non-public session [per RSA 91-A:3.II.c.].

5:11 p.m. Nelson moved, and Osgood seconded, a motion to adjourn the public meeting to conduct a non-meeting with legal counsel. All three Commissioners voted 'Yes'. The motion carried, unanimously.

Respectfully submitted,

Joe Osgood, Clerk
Board of Commissioners
Sullivan County NH

JO/sjc/df

Date minutes reviewed & ratified:

DocuSign Envelope ID: 3E38544F-CF2B-45EA-B8D1-3B2E93B1EB3A

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Sullivan County 14 Main Street Newport, NH 03773	606	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits* - NH Statutory Limits May Apply, If Not:	
X	**General Liability (Occurrence Form)**	7/1/2020	7/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
	Automobile Liability Deductible Comp and Coll:			Combined Single Limit (Each Accident)	
	☐ Any auto			Aggregate	
X	**Workers' Compensation & Employers' Liability**	7/1/2020	7/1/2021	X Statutory	$2,000,000
				Each Accident	$2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
	Property (Special Risk includes Fire and Theft)			Blanket Limit, Replacement Cost (unless otherwise stated)	

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
	By: *Mary Beth Purcell*
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	Date: 10/26/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and THE EDGEWOOD MANOR INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,026,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

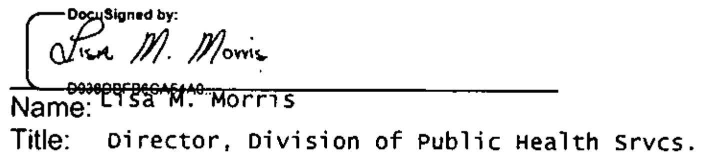
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

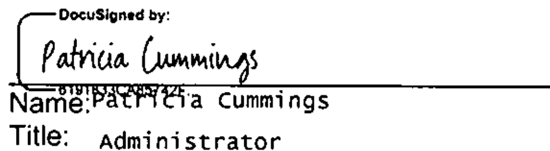
12/18/2020
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

THE EDGEWOOD MANOR INC

12/18/2020
Date



Name: Patricia Cummings
Title: Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $152,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,520 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials PC

Date 12/18/2020

DocuSign Envelope ID: 328A9516-27EA-4082-AA85-3AFA09070FAC

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
PC

Date

12/18/2020

DocuSign Envelope ID: 328A9516-27EA-4082-AA85-3AFA09070FAC

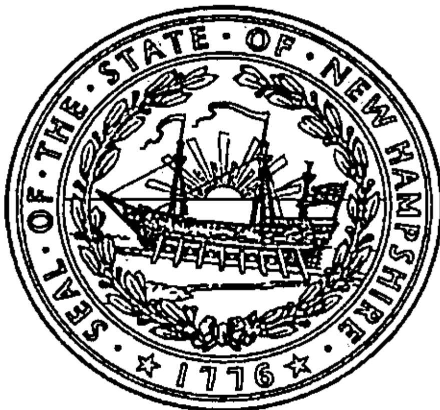
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that EDGEWOOD MANOR, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on September 28, 1984. 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: 80207

Certificate Number: 0005036036



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 30th day of October A.D. 2020.

William M. Gardner

Secretary of State

January 12, 2021

To Whom It May Concern:

Patricia Cummings is authorized to sign contracts for Edgewood Manor, Inc. dba the Edgewood Centre in accordance with her position as the licensed Administrator. Patricia has been authorized to sign contracts since she assumed this position back in 1996 to the present time.

Sincerely,

Patricia M. Ramsey

Patricia M. Ramsey
President/Owner

EDGEWMAN2

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/28/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services, LLC
75 John Roberts Road, Building C
South Portland, ME 04106
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 | FAX (A/C, No): 877-775-0110
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Insurance Company of ME	36277
INSURER B : MEMIC Indemnity Co	11030
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Edgewood Manor Inc.
928 South Street
Portsmouth, NH 03801-5421

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE X OCCUR			NHNHL004758	09/10/2020	09/10/2021	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: POLICY PRO-JECT LOC						GENERAL AGGREGATE	$3,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	$
								$
	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			3102800456	09/10/2020	09/10/2021	X PER STATUTE; OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N: N (Mandatory in NH)	N/A					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
A	Professional Liab Claims Made Basis			NHNHL004758	09/10/2020	09/10/2021	$1,000,000 Ea Incident; $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
This certificate is issued for insured operations usual to Edgewood Manor Inc.

CERTIFICATE HOLDER

Proof of Insurance

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

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The ACORD name and logo are registered marks of ACORD
#S30286486/M30286161 MKYZP

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and FRANKLIN HOME FOR THE AGED ASSOCIATION ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,903,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/12/2021
Date

DocuSigned by: Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

FRANKLIN HOME FOR THE AGED ASSOCIATION

1/12/2021
Date

DocuSigned by: Mary E. Miller
Name: Mary E. Miller
Title: Exective Director

DocuSign Envelope ID: 283E44C4-C69B-42BD-A004-AAF0A8627EB2

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 29,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 290 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials MEM
Date 1/12/2021

DocuSign Envelope ID: 283E44C4-C69B-42BD-A004-AAF0A8627EB2

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

   ☐ Surveillance

   ☐ Outbreak/Response

   ☐ County rate greater than 5%

   ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS

MEM

Date

1/12/2021

DocuSign Envelope ID: 283E44C4-C69B-42BD-A004-AAF0A8627EB2

State of New Hampshire

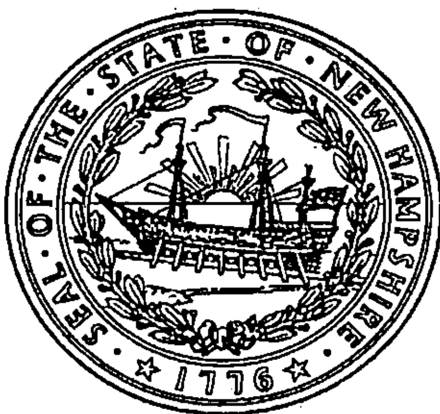
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that FRANKLIN HOME FOR THE AGED ASSOCIATION is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on October 13, 1938. 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: 60606

Certificate Number: 0005040481



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 10th day of November A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Christopher Seufert, hereby certify that:

1. I am a duly elected Officer of Franklin Home for the Aged Association.

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 October 21, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Mary E. Miller, Executive Director is duly authorized on behalf of Franklin Home for the Aged Association 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: 1/12/21

Signature of Elected Officer
Name: Christopher Seufert
Title:

FRANKHOM1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/11/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
3 Executive Park Drive, Suite 300
Bedford, NH 03110
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Lexington Insurance Company	19437
INSURER B : AIM Mutual Insurance Company	33758
INSURER C : American Alternative Insurance Corp	19720
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Franklin Home For The Aged Association
dba Peabody Home
24 Peabody Place
Franklin, NH 03235

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			SLG4NL800000300	03/13/2020	03/13/2021	EACH OCCURRENCE	$1,000,000
	X CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$15,000
							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:							$
C	AUTOMOBILE LIABILITY			SLHHHA105082901	03/13/2020	03/13/2021	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
A	☐ UMBRELLA LIAB ☐ OCCUR			SLG4NE900000400	03/13/2020	03/13/2021	EACH OCCURRENCE	$1,000,000
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$1,000,000
	DED X RETENTION $10000							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			ECC60040000272020A	06/01/2020	06/01/2021	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A					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
A	Professional Liab			SLG4NL800000300	03/13/2020	03/13/2021	$1,000,000 ea. claim $3,000,000 aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
This certificate covers all operations usual and customary to the business of the insured.

CERTIFICATE HOLDER
State of New Hampshire
Dept. 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

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#S30408719/M30408711 LCACA

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Genesis Administrative Services, LLC. ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $3,670,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

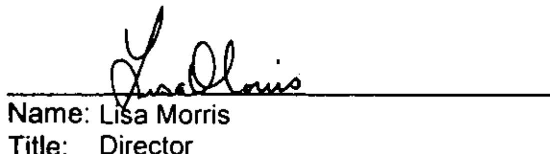
   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

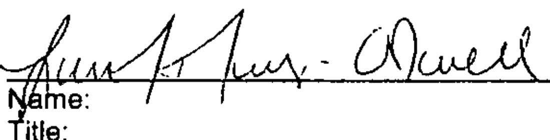
State of New Hampshire
Department of Health and Human Services



01/14/2021
Date

Name: Lisa Morris
Title: Director

Genesis Administrative Services, LLC.



1/11/2021
Date

Name:
Title:

Exhibit A-2, Amendment 1

Facility List

Project ID	Facility Name	Vendor (	Address	City	State	Zip	ɔtal TEST	Reimbursement Amount
SS-2021-DPHS-11-LONGT-11	Applewood	306096	8 Snow Road	Winchester	NH	03470	640	$ 64,000.00
SS-2021-DPHS-11-LONGT-11	Bedford Hills Center	234296	30 Colby Court	Bedford	NH	03110	1122	$ 112,200.00
SS-2021-DPHS-11-LONGT-11	Country Village Healthcare	244239	US Route #3	West Stewartstown	NH	03597	586	$ 58,600.00
SS-2021-DPHS-11-LONGT-11	Crestwood	306497	40 Crosby Street	Milford	NH	03055	640	$ 64,000.00
SS-2021-DPHS-11-LONGT-11	Elm Wood Center Claremont	241721	290 Hanover St	Claremont	NH	03743	500	$ 50,000.00
SS-2021-DPHS-11-LONGT-11	Exeter Center	233419	8 Hampton Road	Exeter	NH	03833	760	$ 76,000.00
SS-2021-DPHS-11-LONGT-11	Hackett Hill Center	263830	191 Hackett Hill Road	Manchester	NH	03102	668	$ 66,800.00
SS-2021-DPHS-11-LONGT-11	Harris Hill Center	244265	20 Maitland Street	Concord	NH	03301	704	$ 70,400.00
SS-2021-DPHS-11-LONGT-11	Keene Center	244264	677 Court Street	Keene	NH	03431	832	$ 83,200.00
SS-2021-DPHS-11-LONGT-11	Laconia Rehabilitation Center	280154	175 Blueberry Lane	Laconia	NH	03246	1195	$ 119,500.00
SS-2021-DPHS-11-LONGT-11	Lafayette Center	244268	93 Main Street	Franconia	NH	03580	546	$ 54,600.00
SS-2021-DPHS-11-LONGT-11	Langdon Place of Dover	235654	60 Middle Road	Dover	NH	03820	760	$ 76,000.00
SS-2021-DPHS-11-LONGT-11	Langdon Place of Keene	235658	136 1/2 Arch Street	Keene	NH	03431	810	$ 81,000.00
SS-2021-DPHS-11-LONGT-11	Lebanon Center	244240	24 Old Etna Road	Lebanon	NH	03766	1058	$ 105,800.00
SS-2021-DPHS-11-LONGT-11	Mineral Springs	231518	1251 White Mountain Highway	North Conway	NH	03860	677	$ 67,700.00
SS-2021-DPHS-11-LONGT-11	Mountain Ridge Center	244266	7 Baldwin Street	Franklin	NH	03235	794	$ 79,400.00
SS-2021-DPHS-11-LONGT-11	Oceanside Skilled Nursing and Rehabilitation	241785	22 Tuck Road	Hampton	NH	03842	720	$ 72,000.00
SS-2021-DPHS-11-LONGT-11	Pheasant Wood	306498	50 Pheasant Road	Peterborough	NH	03458	762	$ 76,200.00
SS-2021-DPHS-11-LONGT-11	Pleasant View Center	244263	239 Pleasant Street	Concord	NH	03301	1152	$ 115,200.00
SS-2021-DPHS-11-LONGT-11	Ridgewood Center	244241	25 Ridgewood Road	Bedford	NH	03110	988	$ 98,800.00
SS-2021-DPHS-11-LONGT-11	Rochester Manor	270757	40 Whitehall Road	Rochester	NH	03867	801	$ 80,100.00
SS-2021-DPHS-11-LONGT-11	The Elms Center	234295	1276 Hanover Street	Manchester	NH	03104	497	$ 49,700.00
SS-2021-DPHS-11-LONGT-11	Wolfeboro Bay Center	233423	39 Clipper Drive	Wolfeboro	NH	03894	744	$ 74,400.00
								$ 1,795,600.00

Grantee Initials________

Date__________

GRANT AGREEMENT EXHIBIT B

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $1,795,600, for the number of test listed in Exhibit A-2 – Facility List.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 test performed, during the period specified in Section 3, and will not exceed the number of staff in each facility identified in Exhibit A-2 – Facility List, Amendment #1. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

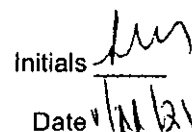
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials
Date


NH DIVISION OF
Public Health Services
Department of Health and Human Services

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name: [signature]   Title: VP Operations   Date: 1/11/21

CERTIFICATE OF AUTHORITY

Michael Berg

I, _______Michael Berg____________, 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 **Genesis Administrative Services LLC**
(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 11,2021**, at which a quorum of the Directors/shareholders were present and voting.
(Date)

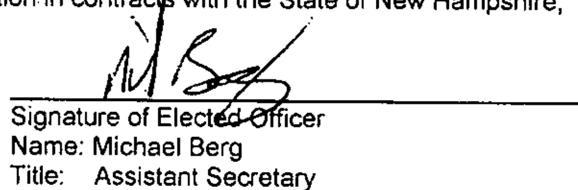
VOTED: That **Lauren Murrav. LNHA. Vice President Of Operations** (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of **Genesis Administrative Services LLC** to enter into contracts or agreements with
(Name of Corporation/ LLC)

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: 1/11/2021



Signature of Elected Officer
Name: Michael Berg
Title: Assistant Secretary

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/25/2020

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

CN130089801-STND-GAWP-20-21

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hudson Excess Insurance Company	14484
INSURER B : Liberty Mutual Fire Insurance Co	23035
INSURER C : AIU Insurance Co.	19399
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Genesis Healthcare, Inc.
101 East State Street
Kennett Square, PA 19348

COVERAGES **CERTIFICATE NUMBER:** NYC-010766282-11 **REVISION NUMBER:** 0

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			HFF100067-2005	12/01/2020	12/01/2021	EACH OCCURRENCE	$ 3,000,000
	X CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 3,000,000
							MED EXP (Any one person)	$ EXCLUDED
							PERSONAL & ADV INJURY	$ 3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY			AS2-631-004097-340	12/01/2020	12/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO			SIR: $250,000			BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			045886637 (AOS)	11/15/2020	02/15/2021	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N	N/A		Deductible:$1,500,000			E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below			(Continued on Acord 101)			E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Medical Professional Liability			HFF100067-2005	12/01/2020	12/01/2021	Each Medical Incident:	3,000,000
							Aggregate:	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
*GL and MPL Policy subject a combined $3,000,000 policy aggregate and is inclusive of the applicable policy deductible.

The Named Insured is Self Insured for auto physical damages. Evidence of Insurance

CERTIFICATE HOLDER

7 Baldwin Street Operations LLC
d/b/a Mountain Ridge Center
7 Baldwin Street
Franklin, NH 3235

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
of Marsh USA Inc.

Michael. P. Walsh

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The ACORD name and logo are registered marks of ACORD

AGENCY CUSTOMER ID: CN130089801
LOC #: Boston

ADDITIONAL REMARKS SCHEDULE

AGENCY		NAMED INSURED
MARSH USA, INC.		Genesis Healthcare, Inc. 101 East State Street Kennett Square, PA 19348
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Other WC policies:

States covered: CA
Carrier: American Home Assurance Company
Policy Number: 045886640
Limit:
Employers Liability Each Accident: $2,000,000
Employers Liability Disease-Policy Limit: $2,000,000
Employers Liability Disease-Each Employee: $2,000,000
Deductible: $1,500,000

States covered: MA,ND,WA,WI,WY
Carrier: New Hampshire Insurance Company
Policy Number: 045886639
Limit:
Employers Liability Each Accident: $1,000,000
Employers Liability Disease-Policy Limit: $1,000,000
Employers Liability Disease-Each Employee: $1,000,000
Deductible: $1,500,000

States covered: FL
Carrier: AIU Insurance Company
Policy Number: 045886638
Limit:
Employers Liability Each Accident: $1,000,000
Employers Liability Disease-Policy Limit: $1,000,000
Employers Liability Disease-Each Employee: $1,000,000
Deductible: $1,500,000

States covered: OH
Carrier: National Union Fire Insurance Company of Pittsburgh, PA
Policy Number: XWC 6559378
Limit:
Employers Liability Each Accident: $1,000,000
Employers Liability Disease-Policy Limit: $1,000,000
Self insured retention: $1,500,000

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The ACORD name and logo are registered marks of ACORD

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and GREENLEAF PROPERTIES INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,930,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
D038DBFB8CA54A0...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

GREENLEAF PROPERTIES INC

12/18/2020
Date

DocuSigned by:
Christopher Martin
4F2262D1075B4D4...
Name: Christopher Martin
Title: President

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 56,400.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 564 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

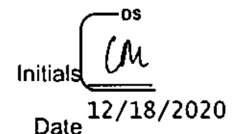
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.



Initials CM

Date 12/18/2020

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New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
CM

Date

12/18/2020

DocuSign Envelope ID: F71B2113-DD11-43B3-B60A-1337EE1819F1

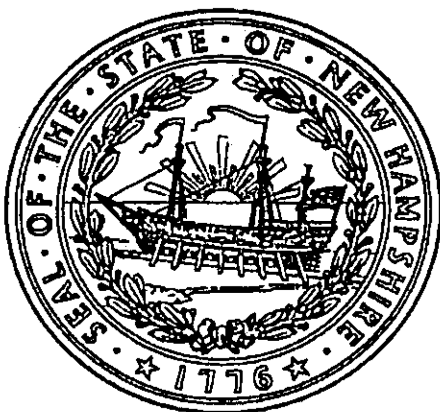
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that GREENLEAF PROPERTIES, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on June 07, 1982. 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: 47907

Certificate Number: 0005032619



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 23rd day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Christopher Martin, hereby certify that:

1. I am the sole shareholder and director of Greenleaf Properties.
   (Corporation)
2. On 12/23/20 (date), Christopher Martin (name), the sole shareholder and director of Greenleaf Properties Inc (corporation), voted to enter into a contract or agreement with the State of New Hampshire and any of its agencies or departments and further authorized Christopher Martin (name) to execute any and all documents, agreements and other instruments.
3. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that I have full authority to bind the corporation. To the extent that there are any limits on my authority to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.
4. 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: 12/23/20

(Name of Sole Shareholder and Director)

ACORD™ INSURANCE BINDER

DATE: 09/04/20

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON THE REVERSE SIDE OF THIS FORM.

PRODUCER		COMPANY	BINDER #
PHONE (A/C, No, Ext): 253.761.3256	FAX (A/C, No): 253.761.3256	Allied Property and Casualty Ins. C	ACP3047817483

Propel Insurance
Commercial Insurance
1201 Pacific Ave, Suite 1000
Tacoma, WA 98402

EFFECTIVE DATE	EFFECTIVE TIME		EXPIRATION DATE	EXPIRATION TIME
10/25/20	12:01	X AM / PM	12/25/20	X 12:01 AM / NOON

THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY PER EXPIRING POLICY #:

CODE: SUB CODE:

AGENCY CUSTOMER ID: 186742

INSURED: Greenleaf Properties, Inc.
dba Woodlawn Care Center
84 Pine Street
Newport, NH 03773-2005

DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)
Veh#1: 2012 Dodge Ram 2500 Truck
3C6LD5AT4CG188097 NH
Veh#2: 2014 Dodge Ram Promaster Van
3C6TRVPG5EE124628 NH
(See Special Conditions Below)

COVERAGES

TYPE OF INSURANCE	COVERAGE/FORMS	DEDUCTIBLE	COINS %	AMOUNT
PROPERTY — CAUSES OF LOSS: [ ] BASIC [ ] BROAD [X] SPEC	Blanket 1: Combined Bldg & Per Prop	Varies	100	$5,624,722
[X] RCV	Blanket 2: BI/EE Incl Rental Value	72 Hours	100	$1,929,300
[X] Agreed Value	See Spec. Conditions/Other Coverages			

TYPE OF INSURANCE	COVERAGE/FORMS	LIMITS	AMOUNT
GENERAL LIABILITY		EACH OCCURRENCE	$ 1,000,000
[X] COMMERCIAL GENERAL LIABILITY		DAMAGE TO RENTED PREMISES	$ 100,000
[X] CLAIMS MADE [ ] OCCUR		MED EXP (Any one person)	$ 5,000
		PERSONAL & ADV INJURY	$ 1,000,000
	See Spec. Conditions/Other Coverages	GENERAL AGGREGATE	$ 3,000,000
	RETRO DATE FOR CLAIMS MADE: 10/25/2005	PRODUCTS - COMP/OP AGG	$ 3,000,000
AUTOMOBILE LIABILITY		COMBINED SINGLE LIMIT	$ 1,000,000
[X] ANY AUTO		BODILY INJURY (Per person)	$
[ ] ALL OWNED AUTOS		BODILY INJURY (Per accident)	$
[ ] SCHEDULED AUTOS		PROPERTY DAMAGE	$
[ ] HIRED AUTOS		MEDICAL PAYMENTS	$ 5,000
[ ] NON-OWNED AUTOS		PERSONAL INJURY PROT	$
		UNINSURED MOTORIST	$ 1,000,000
			$
AUTO PHYSICAL DAMAGE — DEDUCTIBLE	[ ] ALL VEHICLES [X] SCHEDULED VEHICLES	[X] ACTUAL CASH VALUE	
[X] COLLISION: 1000		[ ] STATED AMOUNT	$
[X] OTHER THAN COL: 1000		[ ] OTHER	
GARAGE LIABILITY		AUTO ONLY - EA ACCIDENT	$
[ ] ANY AUTO		OTHER THAN AUTO ONLY:	
		EACH ACCIDENT	$
		AGGREGATE	$
EXCESS LIABILITY		EACH OCCURRENCE	$ 1,000,000
[X] UMBRELLA FORM		AGGREGATE	$ 1,000,000
[ ] OTHER THAN UMBRELLA FORM	RETRO DATE FOR CLAIMS MADE: 10/25/05	SELF-INSURED RETENTION	$
WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY		[ ] WC STATUTORY LIMITS	
		E.L. EACH ACCIDENT	$
		E.L. DISEASE - EA EMPLOYEE	$
		E.L. DISEASE - POLICY LIMIT	$
SPECIAL CONDITIONS/ OTHER COVERAGES	Named Insureds:	FEES	$
	30 Pine Senior Living, LLC	TAXES	$
	(See attached Spec Conditions/Other Covs page.)	ESTIMATED TOTAL PREMIUM	$

NAME & ADDRESS

[ ] MORTGAGEE [ ] ADDITIONAL INSURED
[ ] LOSS PAYEE

LOAN #

AUTHORIZED REPRESENTATIVE

 NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE CXC00 © ACORD CORPORATION 1993

CONDITIONS

This Company binds the kind(s) of insurance stipulated on the reverse side. The Insurance is subject to the terms, conditions and limitations of the policy(ies) in current use by the Company.

This binder may be cancelled by the Insured by surrender of this binder or by written notice to the Company stating when cancellation will be effective. This binder may be cancelled by the Company by notice to the Insured in accordance with the policy conditions. This binder is cancelled when replaced by a policy. If this binder is not replaced by a policy, the Company is entitled to charge a premium for the binder according to the Rules and Rates in use by the Company.

Applicable in California

When this form is used to provide insurance in the amount of one million dollars ($1,000,000) or more, the title of the form is changed from "Insurance Binder" to "Cover Note".

Applicable in Delaware

The mortgagee or Obligee of any mortgage or other instrument given for the purpose of creating a lien on real property shall accept as evidence of insurance a written binder issued by an authorized insurer or its agent if the binder includes or is accompanied by: the name and address of the borrower; the name and address of the lender as loss payee; a description of the insured real property; a provision that the binder may not be canceled within the term of the binder unless the lender and the insured borrower receive written notice of the cancellation at least ten (10) days prior to the cancellation; except in the case of a renewal of a policy subsequent to the closing of the loan, a paid receipt of the full amount of the applicable premium, and the amount of insurance coverage.

Chapter 21 Title 25 Paragraph 2119

Applicable in Florida

Except for Auto Insurance coverage, no notice of cancellation or nonrenewal of a binder is required unless the duration of the binder exceeds 60 days. For auto insurance, the insurer must give 5 days prior notice, unless the binder is replaced by a policy or another binder in the same company.

Applicable in Nevada

Any person who refuses to accept a binder which provides coverage of less than $1,000,000.00 when proof is required: (A) Shall be fined not more than $500.00, and (B) is liable to the party presenting the binder as proof of insurance for actual damages sustained therefrom.

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SPECIAL CONDITIONS/OTHER COVERAGES (Cont. from page 1)

88 Pine Senior Living, LLC
Greenleaf Properties, Inc.
Martin, Christopher - Individual
Philbin, Pamela - Individual
Woodlawn Nursing Home Resident Trust Account
Woodlawn Properties LLC
dba Woodlawn Care Center

** Continued from Description of Operations/Vehicles/Property Section **
Loc#1: 84 Pine St, Newport, NH 03773-2005
Loc#2: 88 Pine St, Newport, NH 03773
Loc#4: 30 Pine St, Newport, NH 03773

** Continued from General Liability Section **
Coverage: Employee Benefits Liability Retro 10/25/05
Limit: 1,000,000/3,000,000 Deductible $1,000
Coverage: Abuse or Molestation Retro 10/25/05 Limit: 1,000,000/3,000,000
Coverage: Professional Liability Retro 10/25/05 Limit: 1,000,000/3,000,000

** Continued from Property Section **
Bldg/BPP Deductibles - Location 1 $5,000, Locations 2 & 4 $1,000

Granite State Healthcare
and Human Service Trust

PO Box 4197
Concord, NH 03302-4197

Issue Date: Oct 27, 2020

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.

Certificate of Insurance

Certificate Holder

Chris Martin
Greenleaf Properties, Inc.
84 Pine Street
Newport, NH 03773

Companies Affording Coverage

Company Letter A	Granite State HC&HS Trust
Company Letter B	Midwest Employers Casualty Corp.

This policy is effective at 12:00 am on02/01/2020, and will expire at 12:01 am on02/01/2021.

This policy will automatically be renewed unless notified by either party by October 1st of any fund year.

Coverages

This is to certify that the Workers' Compensation and Employer's Liability Insurance has been issued to the insured named above for the policy period indicated, not withstanding 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.

Type of Insurance/Carrier	Policy Number	Effective Date	Expiration Date	LIMITS	
A: Workers' Compensation & Employer's Liability					
				E.L. Each Accident	$1,000,000
Granite State HC&HS Trust	HCHS20200000216	02/01/2020	02/01/2021	E.L. Disease-Pol Limit	$1,000,000
				E.L. Disease-Each Emp	$1,000,000
B: Excess Insurance				Workers' Compensation	Statutory
Midwest Employers Casualty Corp.	EWC009477	02/01/2020	02/01/2021	Employer's Liability	$1,000,000

Description of Operations

☐ Officers Excluded

Member

Chris Martin
Greenleaf Properties, Inc.
84 Pine Street
Newport, NH 03773

Cancellation

Should any of the above described policies be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the certificate holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.

Authorized Representative — Oct 27, 2020 (Date)

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and HANOVER HILL HEALTH CARE CENTER SERVICES ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,002,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:

12/31/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

HANOVER HILL HEALTH CARE CENTER SERVICES

DocuSigned by:

12/28/2020
Date

Name: Lori McIntire
Title: Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $128,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,280 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials LM

Date 12/28/2020

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New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

LM

Date

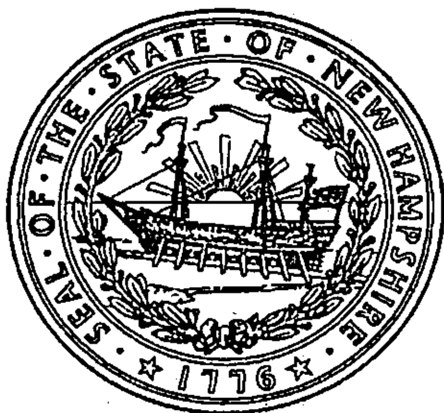
12/28/2020

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 HANOVER HILL HEALTH CARE CENTER SERVICES, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on December 15, 2006. 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: **569040**
Certificate Number: **0005034271**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 27th day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Theodore J. Lee, 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 Hanover Hill Health Care Center Services, Inc.
(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 December 30, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Lori McIntire, Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Hanover Hill Health Care Center Services Inc 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: 1/5/21

Signature of Elected Officer
Name: TED LEE
Title: PRESIDENT

Rev. 03/24/20

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/03/2020

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
FIAI/Cross Insurance 1100 Elm Street Manchester NH 03101	CONTACT NAME: Carrie Morgan PHONE (A/C, No, Ext): (603) 669-3218 FAX (A/C, No): (603) 645-4331 E-MAIL ADDRESS: cmorgan@crossagency.com

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Medical Mutual Insurance Co of Maine	
INSURER B :	The Travelers Indemnity Co. & its Affiliates.	
INSURER C :	New Hampshire Employers Ins Co	13083
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
Hanover Hill Health Care Center Services Inc.
700 Hanover Street
Manchester NH 03104

COVERAGES CERTIFICATE NUMBER: 20-21 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 [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [X] OTHER: Professional Liability			NH NHL 004352	12/01/2020	12/01/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
							Each Occur/Aggregate	$ 1 mill / 3 mill
B	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY			BA-4R751664-20-43-G	12/01/2020	12/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Uninsured motorist	$ 1,000,000
A	[ ] UMBRELLA LIAB [X] OCCUR [X] EXCESS LIAB [ ] CLAIMS-MADE DED [X] RETENTION $ 10,000			NH UMB 004353	12/01/2020	12/01/2021	EACH OCCURRENCE	$ 2,000,000
							AGGREGATE	$ 2,000,000
								$
C	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		ECC60040001082020 (3a.) NH	12/31/2020	12/31/2021	[X] PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
C	Theodore & Deborah Chamberlain Lee excluded from workers compensation							

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

CERTIFICATE HOLDER	CANCELLATION
New Hampshire Department of Health & Human Services Bureau of Contracts & Procurem 129 Pleasant Street Concord NH 03301	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 [signature]

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and HEARTLAND HEALTHCARE CENTER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,949,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/23/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

HEARTLAND HEALTHCARE CENTER LLC

12/23/2020
Date

DocuSigned by:
Malcolm Dean
Name: Malcolm Dean
Title: NHA

DocuSign Envelope ID: F098A54B-D4F2-4312-B782-D67F624890B0

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 75,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 750 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials MD
Date 12/23/2020

DocuSign Envelope ID: F098A54B-D4F2-4312-B782-D67F624890B0

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS MD

Date

12/23/2020

DocuSign Envelope ID: F098A54B-D4F2-4312-B782-D67F62489080

Search Business Names

Back to Home (/online/BusinessInquire)

Search Result

Business Name	Business ID	Homestate Name	Previous Name	Business Type	Principal Office Address	Registered Agent Name	Status
Heartland HealthCare Center, LLC (/online/BusinessInquire/BusinessInformation?businessID=478367)	649995			Domestic Limited Liability Company	901 Suncook Valley Hwy, Epsom, NH, 03234, USA	National Registered Agents, Inc.	Good Standing

Page 1 of 1, records 1 to 1 of 1

Back

NH Department of State, 107 North Main St. Room 204, Concord, NH 03301 -- **Contact Us (/online/Home/ContactUS)**

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CERTIFICATE OF AUTHORITY

Allison Burwin

I, _________Allison E. Burwin____, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of ___Heartland HealthCare Center, LLC d/b/a Epsom HealthCare Center

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 December 24, 2020 at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Malcolm Dean, Administrator

is duly authorized on behalf of Heartland HealthCare Center, LLC d/b/a Epsom HealthCare 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.

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:___December 24, 2020

Signature of Elected Officer
Name: Allison Burwin
Title: Regional Vice President

DocuSign Envelope ID: F098A54B-D4F2-4312-B782-D67F624890B0

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 12/30/2019

PRODUCER

USA Risk Group (Cayman LTD.) (877) 483-1850
P. O. Box 1085, Queensgate House, 5th Floor
Grand Cayman, KY1-1102
Cayman Islands

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.

INSURED

National HealthCare Corporation
100 E. Vine Street
Murfreesboro, TN 37130

INSURERS AFFORDING COVERAGE

INSURER A: Premier Plus Insurance Company, LTD
INSURER B:
INSURER C:
INSURER D:
INSURER E:

COVERAGES This Certificate is not intended to specify all endorsements, coverages, terms, conditions and exclusions of the policies shown.

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY ☑ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☑ OCCUR ☑ Professional Liability ☑ Premises Liability GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PROJECT ☐ LOC	PP 019	01/01/2020	01/01/2021	EACH OCCURRENCE	1,000,000.
					FIRE DAMAGE (Any one fire)	50,000.
					MED EXP (Any one person)	Excluded
					PERSONAL & ADV INJURY	Included
					GENERAL AGGREGATE	3,000,000.
					PRODUCTS - COMP/OP AGG	N/A
					NO Deductible Applie	
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON OWNED AUTOS ☐ $1000 Ded. Collision ☐ $250 Ded Comp				COMBINED SINGLE LIMIT (Each accident)	
					BODILY INJURY (Per person)	
					BODILY INJURY (Per accident)	
					PROPERTY DAMAGE (Per accident)	
	GARAGE LIABILITY ☐ ANY AUTO ☐				AUTO ONLY - EACH ACCIDENT	
					OTHER THAN AUTO ONLY: EA ACC	
					AGG	
	EXCESS LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $ 0				EACH OCCURRENCE	
					AGGREGATE	
A	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY	10804014-15	01/01/2020	01/01/2021	☑ WC STATUTORY LIMITS ☐ OTHER	
					E.L. EACH ACCIDENT	1,000,000
					E.L. DISEASE-POLICY LIMIT	1,000,000
					E.L. DISEASE-EA EMPLOYEE	1,000,000
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

Evidence of Insurance - Heartland HealthCare Center, LLC d/b/a Epsom HealthCare Center

CERTIFICATE HOLDER

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

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEROF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL30 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 COMPANY, ITS AGENTS OR REPRESENTATIVES

AUTHORIZED REPRESENTATIVE
Paul Macey

 ACORD CORPORATION 1988

Certificate No

Holder Identifier :

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and HOLY CROSS HEALTH CENTER INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,931,600

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/31/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

HOLY CROSS HEALTH CENTER INC

12/29/2020
Date

DocuSigned by:
Scott M. Wojtkiewicz
Name: Scott M. Wojtkiewicz
Title: Administrator

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 57,600.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 576 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials SMW
Date 12/29/2020

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

SMB

Date

12/29/2020

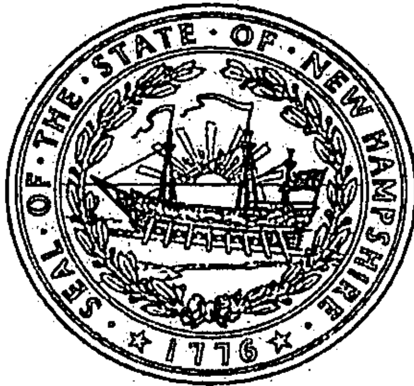
DocuSign Envelope ID: 2175DD66-8243-49C7-95EE-1048C14F8468

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 HOLY CROSS HEALTH CENTER, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on May 23, 1995. 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: **229872**
Certificate Number: **0005033398**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 26th day of October A.D. 2020.

William M. Gardner
Secretary of State

Holy Cross Health Center

357 Island Pond Road, Manchester, NH 03109 Phone: 603-628-3550 Fax: 603-626-6270

Certificate of Authority

CERTIFICATE OF AUTHORITY

I, Sr. Diane Y. Dupere, 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 Holy Cross Health Center, Inc.
(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 Jan. 4, 2021, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Scott Wojtkiewicz (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Holy Cross Health Center, Inc. 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 judgement 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 for 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: January 4, 2021

Signature of Elected Officer
Name: Sr. Diane Y Dupere
Title: U.S. Sector Leader
Board President

DocuSign Envelope ID: 2175DD66-8243-49C7-95EE-1048C14F8468

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/29/2020

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
Waldorf Risk Solutions, LLC
PO Box 590
Huntington NY 11743

CONTACT NAME:
PHONE (A/C, No, Ext): 631-423-9500 | FAX (A/C, No): 631-424-3610
E-MAIL ADDRESS: info@wrs1928.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Certain Underwriters at Lloyds, London - AA1122000	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED HOLSIS
Holy Cross Health Center
357 Island Pond Road
Manchester, NH 03109

COVERAGES CERTIFICATE NUMBER: 17225566 REVISION NUMBER:

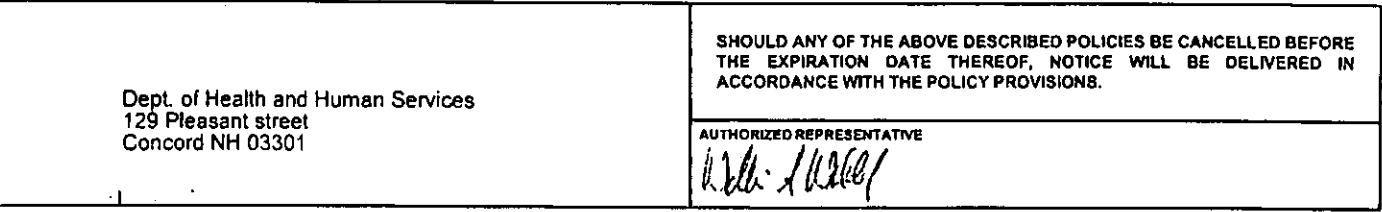
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE 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: [X] POLICY [ ] PRO-JECT [ ] LOC; OTHER:			20W1461	7/1/2020	7/1/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB [X] OCCUR; X EXCESS LIAB CLAIMS-MADE; DED RETENTION $			20XS103	7/1/2020	7/1/2021	EACH OCCURRENCE	$ 1,000,000
							AGGREGATE	$ 1,000,000
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			20W1461	7/1/2020	7/1/2021	Per Claim:	$1,000,000

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

PROOF ONLY.

The Excess Liability will follow the terms and conditions of the General and Professional Liability.



CERTIFICATE HOLDER

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

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Client#: 491562 SISTEHOL1

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/26/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
USI Insurance Services LLC 3 Executive Park Drive, Suite 300 Bedford, NH 03110 855 874-0123	PHONE (A/C, No, Ext): 855 874-0123	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : AIM Mutual Insurance Company	33758
INSURED Holy Cross Health Care Center, Inc. 357 Island Pond Road Manchester, NH 03109	INSURER B :	
	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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040005402020A	08/11/2020	08/11/2021	X PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$500,000
							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	CANCELLATION
Department of Health & Human Services 129 Pleasant Street Concord, NH 03301	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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and JAFFREY REHABILITATION AND NURSING CENTER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,927,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
D938DBF86CA5AA0...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

JAFFREY REHABILITATION AND NURSING CENTER LLC

12/17/2020
Date

DocuSigned by:
Patrick Lyons
AD5E051E0C9E435...
Name: Patrick Lyons
Title: Administrator

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 53,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 532 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials PL
Date 12/17/2020

DocuSign Envelope ID: 1BDE3CC3-ABE5-4E7D-9079-DD839A7E267D

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

PL

Date

12/17/2020

DocuSign Envelope ID: 18DE3CC3-ABE5-4E7D-9079-DD839A7E267D

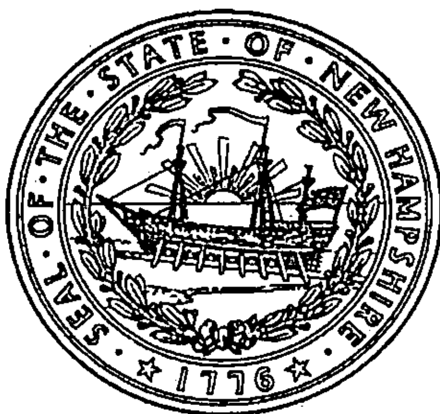
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that JAFFREY REHABILITATION AND NURSING CENTER LLC is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on January 17, 2019. 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: 810933

Certificate Number: 0005032566



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 23rd day of October A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, ____________Akiva Horowitz____, 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 ___Jaffrey Rehabilitation and Nursing Center LLC_______.
(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 ___December 18______________, 2020____, at which a quorum of the Directors/shareholders were present and voting.
(Date)

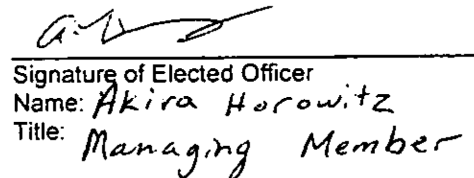
VOTED: That ____Patrick Lyons, Administrator____ (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of ___ Jaffrey Rehabilitation and Nursing Center LLC_ 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:___12/18/2020_________



Signature of Elected Officer
Name: Akira Horowitz
Title: Managing Member

Rev. 03/24/20

DocuSign Envelope ID: 1BDE3CC3-ABE5-4E7D-9079-DD839A7E267D

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/13/2020

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
P&G Brokerage Inc.
1648 61st Street
Brooklyn NY 11204

CONTACT NAME: Rivky Finkel
PHONE (A/C, No, Ext): (718) 854-2818
FAX (A/C, No): (718) 854-3108
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hallmark Specialty Insurance C	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Jaffrey Rehabilitation and Nursing Center LLC; Plantation Realty LLC
20 Plantation Drive
Jaffrey NH 03452

COVERAGES CERTIFICATE NUMBER: CL2051304715 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; [X] Prof. Liability; GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC; OTHER:			75LTP000733-01	05/15/2020	05/15/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
							Employee Benefits	$ 1,000,000
	AUTOMOBILE LIABILITY; [ ] ANY AUTO; [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS; [ ] HIRED AUTOS ONLY [ ] 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	$
								$
	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					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

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

Certificate Holder is listed as Mortgagee and Additional Insured

CERTIFICATE HOLDER

Bank of New Hampshire
62 Pleasant Street
Laconia NH 03246

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

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EVIDENCE OF COMMERCIAL PROPERTY INSURANCE

DATE (MM/DD/YYYY): 05/13/2020

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

PRODUCER NAME, CONTACT PERSON AND ADDRESS	COMPANY NAME AND ADDRESS
PHONE (A/C, No, Ext): (718) 854-2818 P&G Brokerage Inc. Rivky Finkel 1648 61st Street Brooklyn NY 11204	NAIC NO: Hanover Insurance Co. P.O. Box 580045 Charlotte NC 28258-0045 IF MULTIPLE COMPANIES, COMPLETE SEPARATE FORM FOR EACH
FAX (A/C, No): (718) 854-3108 E-MAIL ADDRESS:	POLICY TYPE: Commercial Property
CODE: SUB CODE:	LOAN NUMBER:
AGENCY CUSTOMER ID #: 00010550	POLICY NUMBER: RHYD912400-01
NAMED INSURED AND ADDRESS Jaffrey Rehabilitation and Nursing Center LLC; 20 Plantation Dr LLC; Plantation Realty 20 Plantation Drive Jaffrey NH 03452	EFFECTIVE DATE: 05/15/2020 EXPIRATION DATE: 05/15/2021 ☐ CONTINUED UNTIL TERMINATED IF CHECKED
ADDITIONAL NAMED INSURED(S) 20 Plantation Dr LLC	THIS REPLACES PRIOR EVIDENCE DATED:

PROPERTY INFORMATION (ACORD 101 may be attached if more space is required) ☒ BUILDING OR ☒ BUSINESS PERSONAL PROPERTY

LOCATION / DESCRIPTION
20 Plantation Drive
Jaffrey NH 03452
Loc# 00001

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 EVIDENCE OF PROPERTY INSURANCE 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.

COVERAGE INFORMATION PERILS INSURED ☐ BASIC ☐ BROAD ☐ SPECIAL ☒ Special

COMMERCIAL PROPERTY COVERAGE AMOUNT OF INSURANCE: $ 4,000,000 DED: 5,000

	YES	NO	N/A	
☒ BUSINESS INCOME ☐ RENTAL VALUE				If YES, LIMIT: 1,500,000 ☐ Actual Loss Sustained; # of months:
BLANKET COVERAGE		X		If YES, indicate value(s) reported on property identified above: $
TERRORISM COVERAGE	X			Attach Disclosure Notice / DEC
IS THERE A TERRORISM-SPECIFIC EXCLUSION?		X		
IS DOMESTIC TERRORISM EXCLUDED?		X		
LIMITED FUNGUS COVERAGE		X		If YES, LIMIT: DED:
FUNGUS EXCLUSION (If "YES", specify organization's form used)		X		
REPLACEMENT COST	X			
AGREED VALUE	X			
COINSURANCE		X		If YES, %
EQUIPMENT BREAKDOWN (If Applicable)	X			If YES, LIMIT: 4,000,000 DED: 5,000
ORDINANCE OR LAW - Coverage for loss to undamaged portion of bldg	X			If YES, LIMIT: 4,000,000 DED: 5,000
- Demolition Costs	X			If YES, LIMIT: 100,000 DED: 5,000
- Incr. Cost of Construction	X			If YES, LIMIT: 100,000 DED: 5,000
EARTH MOVEMENT (If Applicable)	X			If YES, LIMIT: 1,000,000 DED: 25,000
FLOOD (If Applicable)	X			If YES, LIMIT: 1,000,000 DED: 25,000
WIND / HAIL INCL ☐ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT: DED:
NAMED STORM INCL ☐ YES ☐ NO Subject to Different Provisions:				If YES, LIMIT: DED:
PERMISSION TO WAIVE SUBROGATION IN FAVOR OF MORTGAGE HOLDER PRIOR TO LOSS				

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.

ADDITIONAL INTEREST

☐ CONTRACT OF SALE ☐ LENDER'S LOSS PAYABLE ☐ LOSS PAYEE
☐ MORTGAGEE ☒ Mortgagee & Loss Payee

NAME AND ADDRESS
Bank of New Hampshire
62 Pleasant Street
Laconia NH 03246

LENDER SERVICING AGENT NAME AND ADDRESS

AUTHORIZED REPRESENTATIVE
[signature]

ACORD 28 (2016/03)

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/13/2020

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
P&G Brokerage Inc.
1648 61st Street
Brooklyn NY 11204

CONTACT NAME: Rivky Finkel
PHONE (A/C, No, Ext): (718) 854-2818 FAX (A/C, No): (718) 854-3108
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Pharmacists Mutual Ins. Co.	
INSURER B :		
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
Jaffrey Rehabilitation and Nursing Center LLC,20 Plantation Drive LLC
20 Plantation Drive
Jaffrey NH 03452

COVERAGES CERTIFICATE NUMBER: CL2051304715 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 CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WCV016322201	05/15/2020	05/15/2021	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

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

CERTIFICATE HOLDER

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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and MEMORIAL ELDER HEALTH SERVICES ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph. 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,929,900

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/21/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

MEMORIAL ELDER HEALTH SERVICES

12/21/2020
Date

DocuSigned by:
Diana J. McLaughlin, FHFMA
Name: Diana J. McLaughlin, FHFMA
Title: CFO

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 55,900.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 559 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials DJMF
Date 12/21/2020

DocuSign Envelope ID: 94CFB282-7DEC-4F04-8873-EDCF94F912E3

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

Date

DS
DJMF

12/21/2020

DocuSign Envelope ID: 94CFB282-7DEC-4F04-8873-EDCF94F912E3

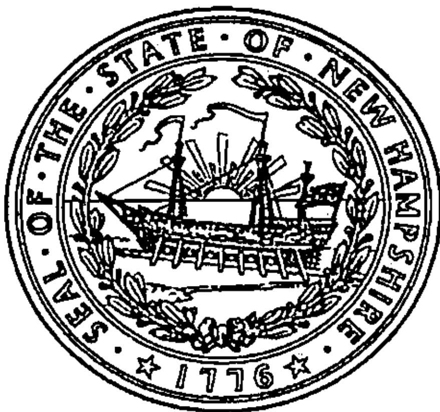
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MEMORIAL ELDER HEALTH SERVICES is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 01, 2016. 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: 749134

Certificate Number: 0004926967



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 8th day of June A.D. 2020.

William M. Gardner
Secretary of State

Memorial Hospital
MaineHealth

December 22, 2020

State of NH
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-3857

To Whom It May Concern:

Please accept this letter as verification that the attached Corporate Resolution effective June 1, 2020 granting Diana McLaughlin, Chief Financial Officer, the authority to execute agreements and contracts on behalf of Memorial Hospital, parent company of Memorial Elder Health Services, continues to be in full force and effect, and has not been revoked.

Sincerely,

MEMORIAL HOSPITAL

Mary B. DeVeau

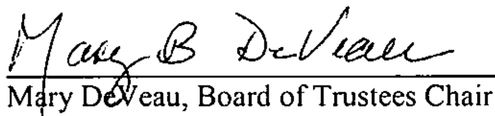
Mary B. DeVeau
Chair, Board of Trustees

THE MEMORIAL HOSPITAL AT NORTH CONWAY, N.H.

CORPORATE RESOLUTION

Resolved, that effective on the 1st of June, 2020, Arthur Mathisen, President, and Diana McLaughlin, Chief Financial Officer, of Memorial Hospital are hereby authorized and directed to execute and deliver lease agreements and contracts on behalf of Memorial Hospital and its subsidiaries under its corporate seal.

I, Mary DeVeau, Chair of the Board of Trustees of Memorial Hospital incorporated under the laws of the State of New Hampshire, hereby certify that the foregoing is a true copy of Resolution duly adopted by the Board of Directors of said corporation at a meeting duly held on the 17th day of June, 2020, at which a quorum was present and voting, and that the same has not been repealed or amended and remains in full force and effect and does not conflict with the by-laws of said corporation.



Mary DeVeau, Board of Trustees Chair

6/17/2020

Date

(Corporate Seal)

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/27/2020

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 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
Medical Mutual Insurance Company of Maine
One City Center PO Box 15275
Portland, ME 04112

CONTACT NAME:
PHONE (A/C, No, Ext): 2077752791 FAX (A/C, No): 2075238320
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Ins Co of Maine	
INSURER B : Medical Mutual Ins Co of Maine	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Memorial Hospital
3073 White Mountain Highway
North Conway NH 03860

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			NH HPL 004270	10/01/2020	10/01/2021	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (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			NH HPL 004270	10/01/2020	10/01/2021	$2,000,000/$4,000,000	

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

Memorial Elder Health Services is an additional insured under the above described policy.

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

Frank W Laurie

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ACORD

THEMEMO-03 CGORDAN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/30/2020

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PRODUCER License # 1780862	CONTACT NAME: Dolly Libby	
HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	PHONE (A/C, No, Ext): (207) 489-7360	FAX (A/C, No):
	E-MAIL ADDRESS: dolly.libby@hubinternational.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Maine Employers' Mutual Insurance Company	11149
INSURED	INSURER B :	
The Memorial Hospital 3073 White Mountain Highway North Conway, NH 03860	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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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 CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		3102806246	1/1/2020	1/1/2021	X PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							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)
RE: Memorial Elder Health Services

CERTIFICATE HOLDER	CANCELLATION
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	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 25 (2016/03)

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and MERRIMAC MEDICAL INVESTORS LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

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1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,986,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

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   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

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4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/31/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

MERRIMAC MEDICAL INVESTORS LLC

12/30/2020
Date

DocuSigned by:
Stephan Pazulski
Name: Stephan Pazulski
Title: Chief Executive Officer

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $112,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,128 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials SP
Date 12/30/2020

DocuSign Envelope ID: 75BC859D-C032-4477-A486-ECA7B530F5CA

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
SP

Date

12/30/2020

State of New Hampshire
Department of State

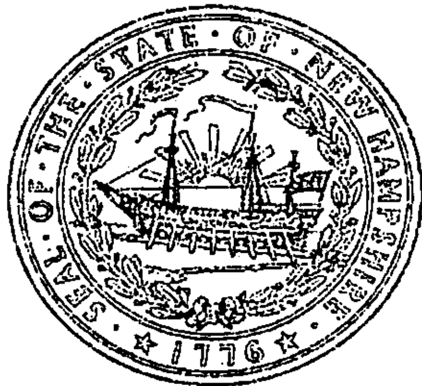
CERTIFICATE OF REGISTERED TRADE NAME
OF
FAIRVIEW SENIOR LIVING

This is to certify that **MERRIMAC MEDICAL INVESTORS, LLC** is registered in this office as doing business under the Trade Name **FAIRVIEW SENIOR LIVING**, at 203 Lowell Road, Hudson, NH, 03051, USA on **7/27/2020 4:30:00 PM**.

The nature of business is **Other / Skilled Nursing Facility**

Expiration Date: **7/27/2025 4:30:00 PM**

Business ID: **847592**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 27th day of July A.D. 2020.

William M. Gardner
Secretary of State

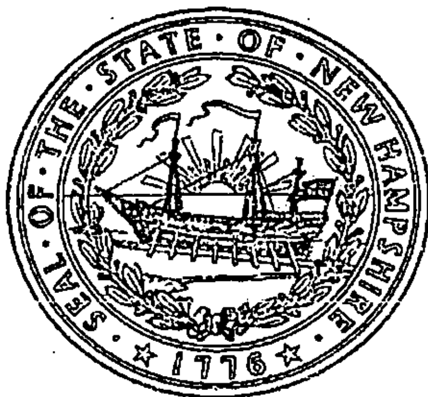
DocuSign Envelope ID: 75BC859D-C032-4477-A486-ECA7B530F5CA

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 FAIRVIEW SENIOR LIVING is a New Hampshire Trade Name registered to transact business in New Hampshire on July 27, 2020. 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: **847592**
Certificate Number: **0004985937**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 26th day of August A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Timothy J Beaulieu, 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 Merrimac Medical Investors, LLC.
(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 December 1, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

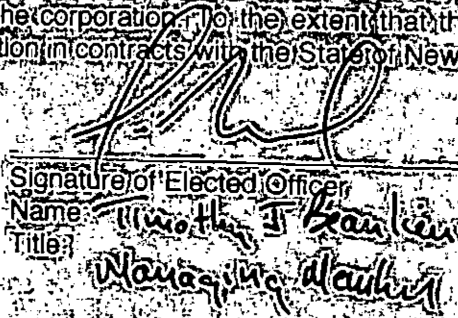
VOTED: That Steve Pazulski, CEO Fairview Senior Living (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Merrimac Medical Investors, LLC 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: 2/17/2021



Signature of Elected Officer
Name: Timothy J Beaulieu
Title: Managing Member

Rev. 03/24/20

DocuSign Envelope ID: 75BC859D-C032-4477-A486-ECA7B530F5CA

MERRI-1 OP ID: AL

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/30/2020

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 703-359-8100
Hamilton Insurance Agency
Alan J. Zuccari, Inc.
4100 Monument Corner Dr. #500
Fairfax, VA 22030

CONTACT NAME: 703-359-8100
PHONE (A/C, No, Ext): 703-359-8100 FAX (A/C, No): 703-359-8108
E-MAIL ADDRESS: aeagle@hamiltoninsurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Columbia Casualty Co.	
INSURER B : Continental Insurance Company	
INSURER C : Technology Insurance Company	
INSURER D : American Cas Co of Reading PA	
INSURER E :	
INSURER F :	

INSURED
Merrimac Medical Investors LLC
t/a Fairview Nursing Center/
Laurel Place Assisted Living/
The Inn at Fairview
203 Lowell Road
Hudson, NH 03051

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
	X CLAIMS-MADE ☐ OCCUR			4022871694	07/01/2020	07/01/2021	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Prof Liab $1M/$3M						MED EXP (Any one person)	$ 5,000
	$25,000 DED						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	X POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$ Included
	OTHER:						Emp Ben.	$ Included
D	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO			4022871677	07/01/2020	07/01/2021	BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
							Coll/Comp Ded	$ 2,000
A	X UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$ 5,000,000
	EXCESS LIAB X CLAIMS-MADE			4022871680	07/01/2020	07/01/2021	AGGREGATE	$ 5,000,000
	DED X RETENTION $ 10,000							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐	N/A		TARNH1036127-00	07/01/2020	07/01/2021	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
B	Crime			4022871663	07/01/2020	07/01/2021	EE Theft	2,800,000
	(Employee Theft)						Ded	1,000

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

Location: Merrimac Medical Investors, LLC dba Fairview Nursing Center/Laurel Place Assisted Living, 203 Lowell Road, Hudson, NH 03051-4909

CERTIFICATE HOLDER

For Information Only

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

Norwood McElveen

ACORD 25 (2016/03)

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Named Insured:
Merrimac Medical Investors, LLC
t/a Fairview Nursing Center
Merrimac Real Estate Investors, LLC
Laurel Place Assisted Living
The Inn at Fairview

FG Healthcare Services, LLC is included as an insured.

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and METRO HEALTH FOUNDATION OF NEW HAMPSHIRE ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,014,900

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/18/2020
Date

DocuSigned by:
Lisa M. Morris
D938D6F86C45450...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

METRO HEALTH FOUNDATION OF NEW HAMPSHIRE

12/17/2020
Date

DocuSigned by:
Rosemary Simino
Name: Rosemary Simino
Title: Administrator

DocuSign Envelope ID: A3FCDA95-A58D-42BC-86D3-97C7BD08A46A

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $140,900.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,409 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials RS
Date 12/17/2020

DocuSign Envelope ID: A3FCDA95-A58D-42BC-86D3-97C7BD08A46A

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
RS

Date

12/17/2020

DocuSign Envelope ID: A3FCDA95-A58D-42BC-86D3-97C7BD08A46A

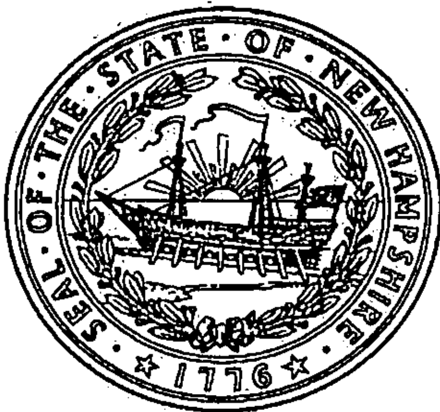
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that METRO HEALTH FOUNDATION OF NEW HAMPSHIRE, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on July 20, 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: **296860**

Certificate Number: **0004967019**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 28th day of July A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Jeanne V. Sanders, 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 Metro Health Foundation of New Hampshire, Inc. d/b/a Golden View Health 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 12/9, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Rosemary Simino Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Metro Health Foundation of New Hampshire, Inc. d/b/a Golden View Health 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: 12/17/2020

Jeanne Sanders
Signature of Elected Officer
Name: Jeanne Sanders
Title: CEO/Director

METROHEA5

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
3 Executive Park Drive, Suite 300
Bedford, NH 03110
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Ironshore Specialty Insurance Co.	25445
INSURER B : Atlantic Charter Insurance Company	44326
INSURER C : Continental Western Insurance Company	10804
INSURER D :	
INSURER E :	
INSURER F :	

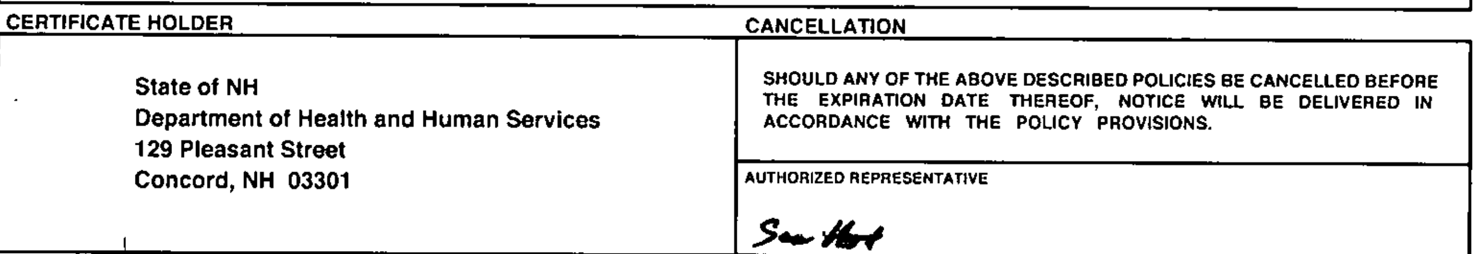
INSURED
Metro Health Foundation of NH d/b/a
Golden View Health Care Center
19 NH Route 104
Meredith, NH 03253

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY; X CLAIMS-MADE; OCCUR			003947001	01/04/2020	01/04/2021	EACH OCCURRENCE	$1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$100,000
							MED EXP (Any one person)	$10,000
							PERSONAL & ADV INJURY	$1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY; X PRO-JECT; LOC						GENERAL AGGREGATE	$3,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	$3,000,000
								$
C	AUTOMOBILE LIABILITY; X ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; X HIRED AUTOS ONLY; X NON-OWNED AUTOS ONLY			CAA527827614	01/04/2020	01/04/2021	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB; OCCUR; X EXCESS LIAB; X CLAIMS-MADE			003947101	01/04/2020	01/04/2021	EACH OCCURRENCE	$5,000,000
	DED; X RETENTION $0						AGGREGATE	$5,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WCA00569601 3A States: NH	01/04/2020	01/04/2021	X 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
A	Professional Liability			003947001	01/04/2020	01/04/2021	$1,000,000 Ea. Incident $3,000,000 Aggregate	

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



CERTIFICATE HOLDER

State of 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

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SCLCA

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and New Hampshire Catholic Charities ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

    1.8 Grant Amount not to exceed: $ $2,332,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

    1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

    1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

    1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

    1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

    1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

    1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

    1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

    1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

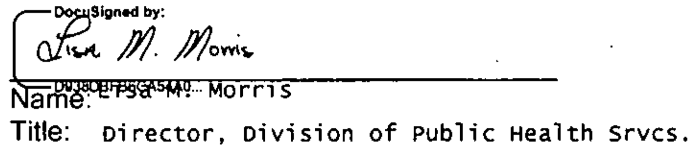
All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/31/2020

Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

New Hampshire Catholic Charities

12/30/2020

Date

Name: David Hildenbrand
Title: CFO

DocuSign Envelope ID: 5D12103D-1D3E-47B9-BC8E-6518A1FD07DD

GRANT AGREEMENT EXHIBIT B

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $457,800, for the number of test listed in Exhibit A-2 – Facility List.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 test performed, during the period specified in Section 3, and will not exceed the number of staff in each facility identified in Exhibit A-2 – Facility List, Amendment #1. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

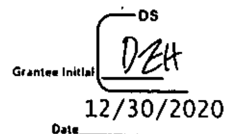
5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials DS DZH

Date 12/30/2020

Exhibit A-2, Amendment 1
Facility List

Facility Name	Vendor Code	Address	City	State	Zip	Phone Number	Total TESTS	Reimbursement Amount
Mt. Carmel Rehab and Nursing Center	233250	235 Myrtle Street	Manchester	NH	3104	(603) 627-3811	1257	$ 125,700.00
St. ann Rehabilitation and Nursing Center	233414	195 Dover Point Road	Dover	NH	03820	(603) 742-2612	528	$ 52,800.00
St. Francis Rehabilitation and Nursing Center	233415	406 Court Street	Laconia	NH	03246	(603) 524-0466	684	$ 68,400.00
St. Teresa Rehabilitation and Nursing Center	233416	519 Bridge Street	Manchester	NH	03104	(603) 668-2373	576	$ 57,600.00
St. Vincent de Paul Rehabilitation and Nursing Center	233417	29 Providence Avenue	Berlin	NH	03570	(603) 752-1820	912	$ 91,200.00
Warde Nursing Home	266873	21 Searles Road	Windham	NH	03087	(603) 890-1290	621	$ 62,100.00


Grantee Initial
Date 12/30/2020

DocuSign Envelope ID: 5D12103D-1D3E-47B9-BC8E-6518A1FD07DD

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
DZH

Date

12/30/2020

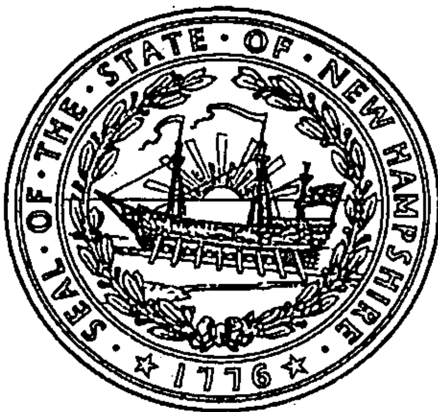
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that NEW HAMPSHIRE CATHOLIC CHARITIES is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on March 07, 1946. 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: 66153

Certificate Number: 0005031648



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 22nd day of October A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, Kevin F. Barrett, 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 New Hampshire Catholic Charities.
(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 September 19, 20 19, at which a quorum of the Directors/shareholders were present and voting.
(Date)

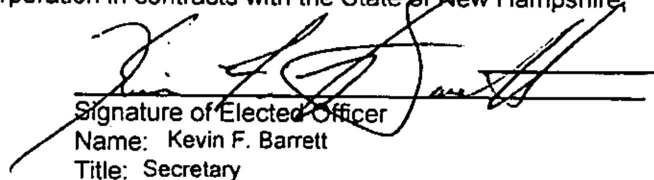
VOTED: That David Hildenbrand, Chief Financial Officer (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of New Hampshire Catholic Charities 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: 1/04/21



Signature of Elected Officer
Name: Kevin F. Barrett
Title: Secretary

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 03/10/2020

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
Porter & Curtis, LLC
225 State Road
Media, PA 19063

CONTACT NAME: Vanessa Maurer
PHONE (A/C, No, Ext): 6108919858 FAX (A/C, No):
E-MAIL ADDRESS: VMaurer@PorterCurtis.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : THE NATIONAL CATHOLIC RISK RETENTION GROUP, INC	10083
INSURER B : PRINCETON EXCESS AND SURPLUS LINES INSURANCE COMPA	10786
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
NH CATHOLIC CHARITIES - ADMINISTRATION
215 Myrtle Street
Manchester, NH 03105

COVERAGES **CERTIFICATE NUMBER:** C000191464 **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:			RRG 10407-23	03/01/2020	03/01/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ Included
							MED EXP (Any one person)	$ Not Covered
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ None Applicable
							PRODUCTS - COMP/OP AGG	$ None Applicable
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
B	UMBRELLA LIAB; X EXCESS LIAB; X OCCUR; X CLAIMS-MADE; DED; RETENTION $			N2-A3-FF-0000022-01	03/01/2020	03/01/2021	EACH OCCURRENCE	$ 14,000,000
							AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability - Incidental Medical			RRG 10407-23	03/01/2020	03/01/2021	$1,000,000 Each Occurence; $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
The limits include applicable retentions.

CERTIFICATE HOLDER

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 [signature]

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Client#: 517491 CATHOCHA1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/20/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
3 Executive Park Drive, Suite 300
Bedford, NH 03110
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 | FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : AIM Mutual Insurance Company	33758
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
New Hampshire Catholic Charities
215 Myrtle Street
Manchester, NH 03104

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE / OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC; OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040006032019A 3A States: NH	11/01/2020	11/01/2021	X 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

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

CERTIFICATE HOLDER

For Insured's Records

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

Sean Hart

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LLJCA

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and NH ODD FELLOWS HOME ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,964,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:
Lisa M. Morris

12/21/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

NH ODD FELLOWS HOME

DocuSigned by:
Anne Purington

12/19/2020
Date

Name: Anne Purington
Title: CEO

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 89,600.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 896 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials AP
Date 12/19/2020

DocuSign Envelope ID: F3AABA34-0A28-42FC-8E0C-C1C4EBEA8E45

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
AP

Date

12/19/2020

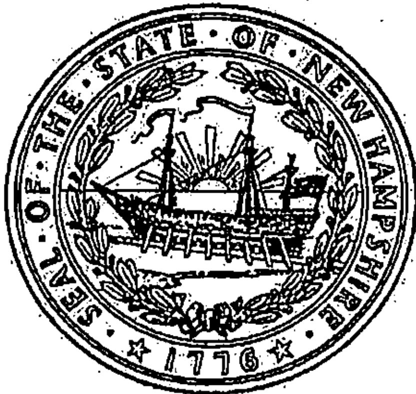
DocuSign Envelope ID: F3AABA34-0A28-42FC-8E0C-C1C4EBEA8E45

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 NEW HAMPSHIRE ODD FELLOWS' HOME is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 15, 1883. 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: **69049**
Certificate Number: **0004952313**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 10th day of July A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Robert W. Wright, Jr, hereby certify that:
(Name of the elected Officer of the Corporation/LLC)

1. I am a duly elected Clerk/Secretary/Officer of New Hampshire Odd Fellows Home, Inc.
(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 December 16, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Anne M. Purington, Chief Executive Officer (may list more than one person) is duly authorized
(Name and Title of Contract Signatory)
on behalf of New Hampshire Odd Fellows home, Inc 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: 1-6-2021

Signature of Elected Officer
Name: Robert W. wright, Jr
Title: President

Rev. 03/24/20

DocuSign Envelope ID: F3AABA34-0A28-42FC-8E0C-C1C4EBEA8E45

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 7/14/2020

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 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
THE ROWLEY AGENCY INC.
45 Constitution Avenue
P.O. Box 511
Concord NH 03302-0511

CONTACT NAME: Rachel Giunta
PHONE (A/C, No, Ext): (603)224-2562 FAX (A/C, No): (603)224-8012
E-MAIL ADDRESS: rgiunta@rowleyagency.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: AIX Special Insurance Company	
INSURER B: Allmerica Financial Benefits	41840
INSURER C: New Hampshire Employers Ins Co	13083
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
New Hampshire Odd Fellows Home Inc., DBA: Presidential Oa
200 Pleasant Street
Concord NH 03301-2599

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	COMMERCIAL GENERAL LIABILITY; [X] CLAIMS-MADE [ ] OCCUR; [X] GL/PROF/EBL; GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC; OTHER:			L1V-D242936 02	5/1/2020	5/1/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
							Professional Liability	$ 1,000,000
B	AUTOMOBILE LIABILITY; [X] ANY AUTO; [ ] ALL OWNED AUTOS; [ ] SCHEDULED AUTOS; [X] HIRED AUTOS; [X] NON-OWNED AUTOS			AWN D240860	5/1/2020	5/1/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Underinsured motorist combined sl	$ 1,000,000
A	[ ] UMBRELLA LIAB [ ] OCCUR; [X] EXCESS LIAB [ ] CLAIMS-MADE; [ ] DED [X] RETENTION $ 0			L1V-D242937-02	5/1/2020	5/1/2021	EACH OCCURRENCE	$ 5,000,000
							AGGREGATE	$ 5,000,000
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) [N]; If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		3A State: NH; ECC-600-4000248-2020A	5/1/2020	5/1/2021	[X] 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
A	Professional Liability			L1V-D242936 02	5/1/2020	5/1/2021	Each Claim	$1,000,000
							Occurrence/Claims Made	$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Covering operations usual to insured through out the policy term.

CERTIFICATE HOLDER

- Information Only -

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
Rachel Giunta/RG Rachel A Giunta

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The ACORD name and logo are registered marks of ACORD

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and PEAK HEALTHCARE AT KEENE LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,938,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

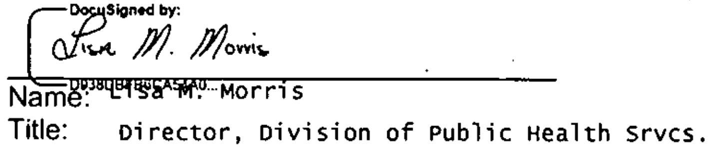
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

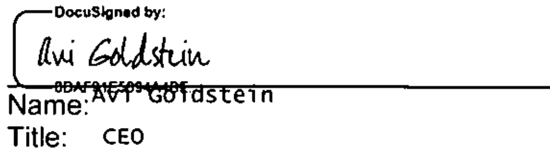
State of New Hampshire
Department of Health and Human Services

1/4/2021
Date


Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

PEAK HEALTHCARE AT KEENE LLC

1/4/2021
Date


Name: Avi Goldstein
Title: CEO

DocuSign Envelope ID: A7B63E70-7886-4D24-8B5D-F18928D1CE79

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 64,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 640 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials AG
Date 1/4/2021

DocuSign Envelope ID: A7B63E70-7886-4D24-8B5D-F18928D1CE79

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
AG

Date

1/4/2021

DocuSign Envelope ID: A7B63E70-7886-4D24-8B5D-F18928D1CE79

State of New Hampshire

Department of State

CERTIFICATE OF REGISTERED TRADE NAME

OF

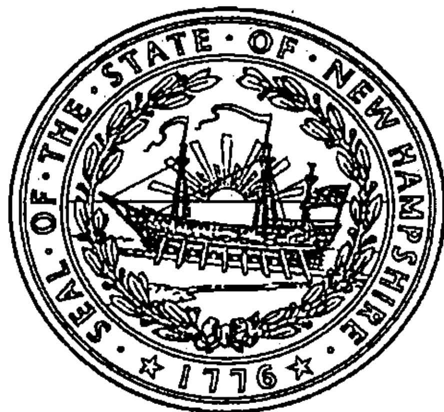
ALPINE HEALTHCARE CENTER

This is to certify that **PEAK HEALTHCARE AT KEENE LLC** is registered in this office as doing business under the Trade Name **ALPINE HEALTHCARE CENTER**, at **298 MAIN STREET, Keene, NH, 03431, USA** on **10/21/2020**

The nature of business is **Health Care and Social Assistance - Nursing Care Facilities (Skilled Nursing Facilities)**

Expiration Date: **10/21/2025**

Business ID: **853979**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 21st day of October A.D. 2020.

William M. Gardner
Secretary of State

DocuSign Envelope ID: A7B63E70-7886-4D24-8B5D-F18928D1CE79

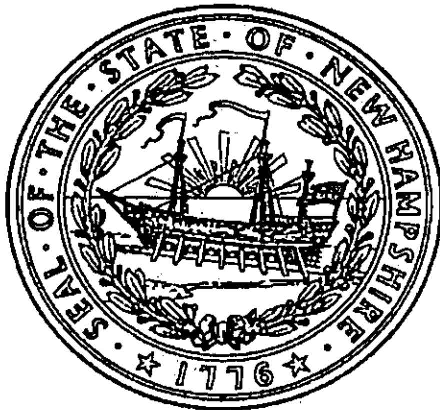
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that ALPINE HEALTHCARE CENTER is a New Hampshire Trade Name registered to transact business in New Hampshire on October 21, 2020. 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: **853979**

Certificate Number : **0005031210**



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this **21st** day of **October** A.D. **2020.**

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY/VOTE
(Limited Liability Company)

I, Zisha Margulies ______________________, hereby certify that:
(Name of Sole Member/Manager of Limited Liability Company, Contract Signatory – Print Name)

1. I am the Sole Member/Manager of the Company of Avrohom Goldstein ______.
(Name of Limited Liability Company)

2. I hereby further certify and acknowledge that the State of New Hampshire will rely on this certification as evidence that I have full authority to bind Peak Healthcare at Keene LLC ______
(Name of Limited Liability Company)

and that no corporate resolution, shareholder vote, or other document or action is necessary to grant me such authority.

[signature]
____
(Contract Signatory - Signature)

1/4/2021
____
(Date)

STATE OF ______________________

COUNTY OF ______________________

On this the ______ day of ______________ 20 ____, before me ______________________,
(Day) (Month) (Yr) (Name of Notary Public / Justice of the Peace)

the undersigned officer, personally appeared ______________________, known to me (or
(Contract Signatory – Print Name)

satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof, I hereunto set my hand and official seal.

(NOTARY SEAL)

____
(Notary Public / Justice of the Peace -Signature)

Commission Expires: ______________________

DocuSign Envelope ID: A7B63E70-7886-4D24-8B5D-F18928D1CE79

MRCSN-1 OP ID: BB

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/04/2021

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 212-687-4600
Onecap Services LLC
77 Spruce Street
Cedarhurst, NY 11516

CONTACT NAME:
PHONE (A/C, No, Ext): 212-687-4600 FAX (A/C, No): 516-612-6137
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	TDC Specialty Underwriters	
INSURER B :	National Indemnity Co.	
INSURER C :	Redwood Fire & Casualty Ins Co	
INSURER D :	Great American Ins Co	16691
INSURER E :		
INSURER F :		

INSURED
Peak Healthcare at Keene LLC
d/b/a Alpne Healthcare Center
Keene SNF Realty LLC
298 Main Street
Keene, NH 03431

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
	X CLAIMS-MADE ☐ OCCUR	X	X	LTP-01238-20-00	11/19/2020	11/19/2021	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Prior Acts: 11/19						MED EXP (Any one person)	$ 5,000
	X Deductible $100,0						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	☐ POLICY ☐ PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$ 1,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	☐ ANY AUTO	X	X	73APB004068	07/14/2020	07/14/2021	BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY X 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 $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐	N/A	X	WMWC114868	11/19/2020	11/19/2021	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
A	Prof Liability			LRP-01238-20-00	11/19/2020	11/18/2021	Each Inci	1,000,000
D	Crime			SAA E651971-00-00	11/19/2020	11/19/2021	Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Location: 298 Main Street, Keene, NH 03431
As required by written contract and per policy form, Certificate Holder is included as Additional Insured. A waiver of subrogation applies.
Certificate holder will receive 30 days written notice of cancellation, 10 days for nonpayment of premium.

CERTIFICATE HOLDER

Congressional Bank, a Maryland
chartered commercial bank ISAOA
4445 Willard Avenue
Suite 1000
Chevy Chase, MD 20815

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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and PEAK HEALTHCARE AT PORTSMOUTH LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,975,900

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

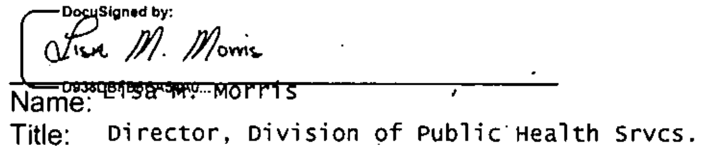
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

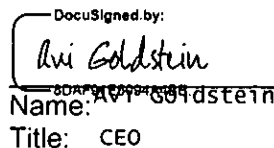
1/4/2021
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

PEAK HEALTHCARE AT PORTSMOUTH LLC

1/4/2021
Date



Name: Avi Goldstein
Title: CEO

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $101,500.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,015 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials AG

Date 1/4/2021

DocuSign Envelope ID: B208C2DF-F4BB-4AAB-84CB-862F46D7BA7C

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
AG

Date

1/4/2021

DocuSign Envelope ID: B208C2DF-F4BB-4AAB-84CB-862F46D7BA7C

State of New Hampshire

Department of State

CERTIFICATE OF REGISTERED TRADE NAME

OF

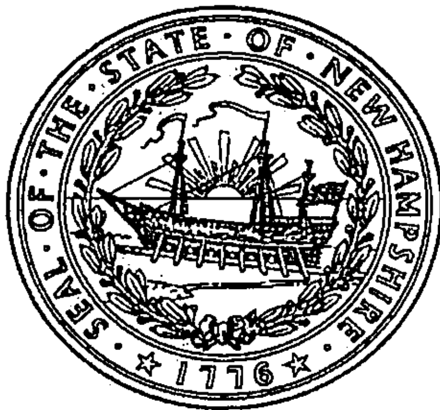
CEDAR HEALTHCARE CENTER

This is to certify that **PEAK HEALTHCARE AT PORTSMOUTH LLC** is registered in this office as doing business under the Trade Name **CEDAR HEALTHCARE CENTER,** at **188 JONES AVENUE, Portsmouth, NH, 03801, USA** on **10/21/2020**

The nature of business is **Health Care and Social Assistance - Nursing Care Facilities (Skilled Nursing Facilities)**

Expiration Date: **10/21/2025**

Business ID: **853977**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 21st day of October A.D. 2020.

William M. Gardner
Secretary of State

DocuSign Envelope ID: B208C2DF-F4BB-4AAB-84CB-862F46D7BA7C

State of New Hampshire

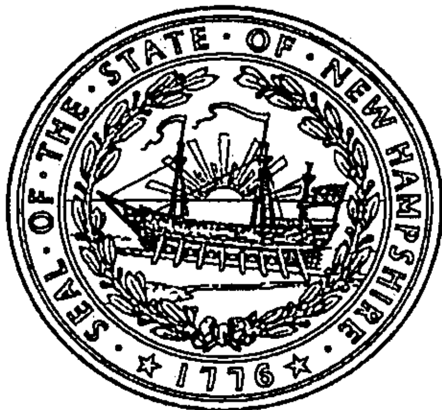
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that CEDAR HEALTHCARE CENTER is a New Hampshire Trade Name registered to transact business in New Hampshire on October 21, 2020. 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: **853977**

Certificate Number : **0005031216**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this **21st** day of **October** A.D. **2020**.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY/VOTE
(Limited Liability Company)

I, Zisha Margulies __________________________, hereby certify that:
(Name of Sole Member/Manager of Limited Liability Company, Contract Signatory – Print Name)

1. I am the Sole Member/Manager of the Company of Avrohom Goldstein __________.
(Name of Limited Liability Company)

2. I hereby further certify and acknowledge that the State of New Hampshire will rely on this certification as evidence that I have full authority to bind Peak Healthcare at Portsmouth LLC ________
(Name of Limited Liability Company)

and that no corporate resolution, shareholder vote, or other document or action is necessary to grant me such authority.

[signature]
____
(Contract Signatory - Signature)

1/4/2021
____
(Date)

STATE OF ____________________

COUNTY OF ____________________

On this the _____ (Day) day of __________ (Month) 20 ___ (Yr), before me ____________________ (Name of Notary Public / Justice of the Peace), the undersigned officer, personally appeared ____________________ (Contract Signatory – Print Name), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof, I hereunto set my hand and official seal.

(NOTARY SEAL)

____
(Notary Public / Justice of the Peace -Signature)

Commission Expires: ____________________

DocuSign Envelope ID: B208C2DF-F4BB-4AAB-84CB-862F46D7BA7C

MRCSN-1 OP ID: BB

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/04/2021

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 212-687-4600
Onecap Services LLC
77 Spruce Street
Cedarhurst, NY 11516

CONTACT NAME:
PHONE (A/C, No, Ext): 212-687-4600 FAX (A/C, No): 516-612-6137
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : TDC Specialty Underwriters	
INSURER B : National Indemnity Co.	
INSURER C : Redwood Fire & Casualty Ins Co	
INSURER D : Great American Ins Co	16691
INSURER E :	
INSURER F :	

INSURED
Peak Healthcare at Portsmouth LLC
d/b/a Cedar Healthcare Center
Portsmouth SNF Realty LLC
188 Jones Ave
Portsmouth, NH 03801

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; X CLAIMS-MADE ☐ OCCUR; X Prior Acts: 11/19; X Deductible $100,0; GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT X LOC; OTHER:	X	X	LTP-01238-20-00	11/19/2020	11/19/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
B	AUTOMOBILE LIABILITY; ☐ ANY AUTO; ☐ OWNED AUTOS ONLY X SCHEDULED AUTOS; ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY	X	X	73APB004068	07/14/2020	07/14/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR; ☐ EXCESS LIAB ☐ CLAIMS-MADE; DED ☐ RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ☐; If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	X	WMWC114868	11/19/2020	11/19/2021	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
A	Prof Liability			LTP-01238-20-00	11/19/2020	11/19/2021	Each Inci	1,000,000
D	Crime			SAA E651971-00-00	11/19/2020	11/19/2021	Aggregate	3,000,000

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

Location: 188 Jones Ave, Portsmouth, NH 03801
As required by written contract and per policy form, Certificate Holder is included as Additional Insured. A waiver of subrogation applies.
Certificate holder will receive 30 days written notice of cancellation, 10 days for nonpayment of premium.

CERTIFICATE HOLDER

Congressional Bank, a Maryland
chartered commercial bank ISAOA
4445 Willard Avenue
Suite 1000
Chevy Chase, MD 20815

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

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The ACORD name and logo are registered marks of ACORD

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and PEAK HEALTHCARE AT ROCHESTER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,942,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/4/2021
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

PEAK HEALTHCARE AT ROCHESTER LLC

1/4/2021
Date

DocuSigned by:
Avi Goldstein
Name: Avi Goldstein
Title: CEO

DocuSign Envelope ID: 6773FF3F-D6ED-4EFC-9E54-2C4375F2FB35

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 68,400.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 684 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials AG
Date 1/4/2021

DocuSign Envelope ID: 6773FF3F-D6ED-4EFC-9E54-2C4375F2FB35

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
AG

Date

1/4/2021

DocuSign Envelope ID: 6773FF3F-D6ED-4EFC-9E54-2C4375F2FB35

State of New Hampshire
Department of State

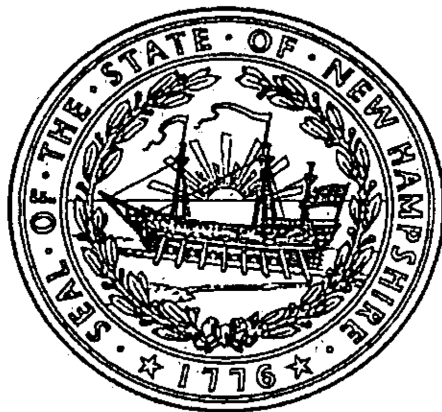
CERTIFICATE OF REGISTERED TRADE NAME
OF
BIRCH HEALTHCARE CENTER

This is to certify that **PEAK HEALTHCARE AT ROCHESTER LLC** is registered in this office as doing business under the Trade Name **BIRCH HEALTHCARE CENTER**, at **62 ROCHESTER HILL ROAD, Rochester, NH, 03867, USA** on **10/21/2020**

The nature of business is **Health Care and Social Assistance - Nursing Care Facilities (Skilled Nursing Facilities)**

Expiration Date: **10/21/2025**

Business ID: **853978**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 21st day of October A.D. 2020.

William M. Gardner
Secretary of State

DocuSign Envelope ID: 6773FF3F-D6ED-4EFC-9E54-2C4375F2FB35

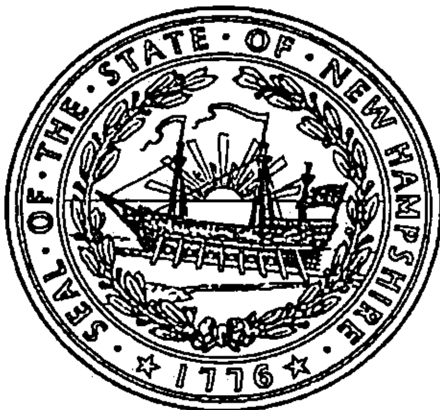
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that BIRCH HEALTHCARE CENTER is a New Hampshire Trade Name registered to transact business in New Hampshire on October 21, 2020. 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: **853978**

Certificate Number : **0005031214**



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this **21st** day of **October** A.D. **2020.**

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY/VOTE
(Limited Liability Company)

I, Zisha Margulies, hereby certify that:
(Name of Sole Member/Manager of Limited Liability Company, Contract Signatory – Print Name)

1. I am the Sole Member/Manager of the Company of Avrohom Goldstein.
(Name of Limited Liability Company)

2. I hereby further certify and acknowledge that the State of New Hampshire will rely on this certification as evidence that I have full authority to bind Peak Healthcare at Rochester LLC
(Name of Limited Liability Company)
and that no corporate resolution, shareholder vote, or other document or action is necessary to grant me such authority.

[signature]
(Contract Signatory - Signature)

1/4/2021
(Date)

STATE OF ______________________

COUNTY OF ______________________

On this the ______ day of ______________ 20 ____, before me ______________________________,
(Day) (Month) (Yr) (Name of Notary Public / Justice of the Peace)

the undersigned officer, personally appeared ______________________________, known to me (or
(Contract Signatory – Print Name)

satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same for the purposes therein contained. In witness whereof, I hereunto set my hand and official seal.

(NOTARY SEAL)

____
(Notary Public / Justice of the Peace -Signature)

Commission Expires: ______________________

DocuSign Envelope ID: 6773FF3F-D6ED-4EFC-9E54-2C4375F2FB35

MRCSN-1 OP ID: BB

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/04/2021

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 212-687-4600
Onecap Services LLC
77 Spruce Street
Cedarhurst, NY 11516

CONTACT NAME:
PHONE (A/C, No, Ext): 212-687-4600 FAX (A/C, No): 516-612-6137
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : TDC Specialty Underwriters	
INSURER B : National Indemnity Co.	
INSURER C : Redwood Fire & Casualty Ins Co	
INSURER D : Great American Ins Co	16691
INSURER E :	
INSURER F :	

INSURED
Peak Healthcare at Rochester LLC
d/b/a Birch Healthcare Center
Rochester SNF Realty LLC
62 Rochester Hill Rd
Rochester, NH 03867

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; X CLAIMS-MADE; OCCUR; X Prior Acts: 11/19; X Deductible $100,0; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY; PRO-JECT; X LOC; OTHER:	X	X	LTP-01238-20-00	11/19/2020	11/19/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
B	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; X SCHEDULED AUTOS; HIRED AUTOS ONLY; NON-OWNED AUTOS ONLY	X	X	73APB004068	07/14/2020	07/14/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB; OCCUR; EXCESS LIAB; CLAIMS-MADE; DED; RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	X	WMWC114868	11/19/2020	11/19/2021	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
A	Prof Liability			LTP-01238-20-00	11/19/2020	11/19/2021	Each Inci	1,000,000
D	Crime			SAA E651971-00-00	11/19/2020	11/19/2021	Aggregate	3,000,000

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

Location: 62 Rochester Hill Rd, Rochester, NH 03867
As required by written contract and per policy form, Certificate Holder is included as Additional Insured. A waiver of subrogation applies.
Certificate holder will receive 30 days written notice of cancellation, 10 days for nonpayment of premium.

CERTIFICATE HOLDER

Congressional Bank, a Maryland
chartered commercial bank ISAOA
4445 Willard Avenue
Suite 1000
Chevy Chase,, MD 20815

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

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The ACORD name and logo are registered marks of ACORD

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and PEARL STREET HEALTHCARE CENTER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,980,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine-testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by:
Lisa M. Morris
D938DBF86CA54A0...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

PEARL STREET HEALTHCARE CENTER LLC

1/5/2021
Date

DocuSigned by:
Beth Skafas
4FE256B2004454F8...
Name: Beth Skafas
Title: Administrator

DocuSign Envelope ID: 63913186-B26E-4042-AB0C-7E157340ED16

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $106,400.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,064 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials BS
Date 1/5/2021

DocuSign Envelope ID: 63913186-B26E-4042-AB0C-7E157340ED16

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
BS

Date

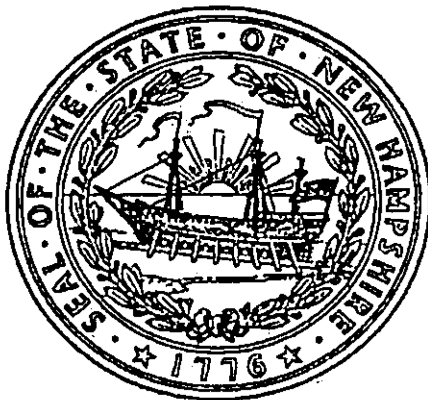
1/5/2021

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 PEARL STREET HEALTHCARE CENTER, LLC is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on May 20, 2011. 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: 650000
Certificate Number: 0005059305



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 21st day of December A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Allison Burun, 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 Pearl Street HealthCare, LLC.
(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 Dec 24, 20 20, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Beth Skafas, Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Pearl Street Healthcare LLC 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: 1/5/21

[signature]
Signature of Elected Officer
Name: Allison E. Burun
Title: Manager

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 12/23/2020

PRODUCER
USA Risk Group (Cayman LTD.) (877) 483-1850
P. O. Box 1085, Queensgate House, 5th Floor
Grand Cayman, KY1-1102
Cayman Islands

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.

INSURED
National HealthCare Corporation
100 E. Vine Street
Murfreesboro, TN 37130

INSURERS AFFORDING COVERAGE

INSURER A: Premier Plus Insurance Company, LTD
INSURER B:
INSURER C:
INSURER D:
INSURER E:

COVERAGES This Certificate is not intended to specify all endorsements, coverages, terms, conditions and exclusions of the policies shown.

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY ☑ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☑ OCCUR ☑ Professional Liability ☑ Premises Liability GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC	PP 020	01/01/2021	01/01/2022	EACH OCCURRENCE	1,000,000.
					FIRE DAMAGE (Any one fire)	50,000.
					MED EXP (Any one person)	Excluded
					PERSONAL & ADV INJURY	Included
					GENERAL AGGREGATE	3,000,000.
					PRODUCTS - COMP/OP AGG	N/A
					NO Deductible Applie	
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON OWNED AUTOS ☐ $1000 Ded. Collision ☐ $250 Ded Comp				COMBINED SINGLE LIMIT (Each accident)	
					BODILY INJURY (Per person)	
					BODILY INJURY (Per accident)	
					PROPERTY DAMAGE (Per accident)	
	GARAGE LIABILITY ☐ ANY AUTO ☐				AUTO ONLY - EACH ACCIDENT	
					OTHER THAN AUTO ONLY: EA ACC	
					AGG	
	EXCESS LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $ 0				EACH OCCURRENCE	
					AGGREGATE	
A	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY	10804014-16	01/01/2021	01/01/2022	☑ WC STATU-TORY LIMITS ☐ OTH-ER	
					E.L. EACH ACCIDENT	1,000,000
					E.L. DISEASE-POLICY LIMIT	1,000,000
					E.L. DISEASE-EA EMPLOYEE	1,000,000
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

Evidence of Insurance - Pearl Street HealthCare Center, LLC d/b/a Maple Leaf HealthCare Center

CERTIFICATE HOLDER
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION
SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEROF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 30 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 COMPANY, ITS AGENTS OR REPRESENTATIVES

AUTHORIZED REPRESENTATIVE
Paul Macey

ACORD 25-S (7/97) ©ACORD CORPORATION 1988

Certificate No
Holder Identifier :

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and PETERBOROUGH RETIREMENT COMMUNITY AT UPLAND FARM INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,008,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to

LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

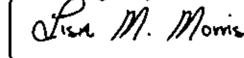
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:

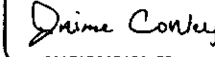


12/31/2020
Date

D938DBFB0CA34B0...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

PETERBOROUGH RETIREMENT COMMUNITY AT UPLAND FARM INC

DocuSigned by:



12/30/2020
Date

909E0FC9D9704F6...
Name: Jaime Conley
Title: CFO

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $134,400.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,344 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

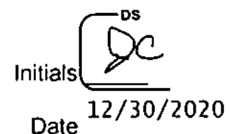
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials 

Date 12/30/2020

DocuSign Envelope ID: F38AD3B4-119A-4538-BF97-1BB5A6E6F629

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

Date

12/30/2020

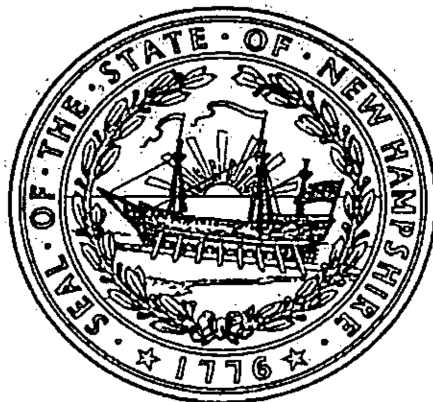
DocuSign Envelope ID: F38AD3B4-119A-4538-BF97-1BB5A6E6F629

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 PETERBOROUGH RETIREMENT COMMUNITY AT UPLAND FARM, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on February 19, 1991. 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: **154609**
Certificate Number: **0005038159**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 4th day of November A.D. 2020.

William M. Gardner
Secretary of State

DocuSign Envelope ID: F38AD3B4-119A-4538-BF97-1BB5A6E6F629

CERTIFICATE OF AUTHORITY

I, **Christopher Flynn** hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of **Peterborough Retirement Community at Upland Farm, Inc. d/b/a "RiverMead"**

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 **October 22, 2020**, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That **William H. James, Jr. (CEO) and Martin James Conley III (CFO)** are duly authorized on behalf of **Peterborough Retirement Community at Upland Farm, Inc. d/b/a "RiverMead"** 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: December 22, 2020

Signature of Elected Officer
Name: **Christopher J. Flynn**
Title: **Board Chair**

DocuSign Envelope ID: F38AD3B4-119A-4538-BF97-1BB5A6E6F629

RIVERME-01 TDENIGHT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/26/2020

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
Johnson, Kendall & Johnson, Inc.
109 Pheasant Run
Newtown, PA 18940

CONTACT NAME:
PHONE (A/C, No, Ext): (215) 968-4741 FAX (A/C, No): (215) 968-0973
E-MAIL ADDRESS: info@jkj.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : AIX Specialty Insurance Company	12833
INSURER B : Allmerica Financial Benefit Insurance	41840
INSURER C : MEMIC Indemnity Company	11030
INSURER D : Massachusetts Bay Insurance Company	22306
INSURER E :	
INSURER F :	

INSURED
Peterborough Retirement Community at Upland Farm, Inc.
150 RiverMead Road
Peterborough, NH 03458

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			L1Y-D460734-02	1/1/2020	1/1/2021	EACH OCCURRENCE	$ 1,000,000
	X CLAIMS-MADE ☐ OCCUR						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
	X POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY			AWY-D460758-02	1/1/2020	1/1/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X 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			L1Y-D460735-02	1/1/2020	1/1/2021	EACH OCCURRENCE	$ 6,000,000
	X EXCESS LIAB X CLAIMS-MADE						AGGREGATE	$ 6,000,000
	DED X RETENTION $ 0							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			3102802040	1/1/2020	1/1/2021	X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N ☐	N/A					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
D	Property			RDY-D460740-02	1/1/2020	1/1/2021	Blanket Bldg & BPP	72,341,633
D	Property			RDY-D460740-02	1/1/2020	1/1/2021	Deductible	50,000

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

CERTIFICATE HOLDER

DHHS
129 Pleasant St
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 25 (2016/03)

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and RANNIE WEBSTER FOUNDATION ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,980,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/21/2020
Date

DocuSigned by: Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

RANNIE WEBSTER FOUNDATION

12/21/2020
Date

DocuSigned by: Tom Argue
Name: Tom Argue
Title: CEO

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $105,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,058 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials TL
Date 12/21/2020

DocuSign Envelope ID: 8DDAF44E-AF2C-4DFB-A942-FFFB4937271C

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS TA

Date

12/21/2020

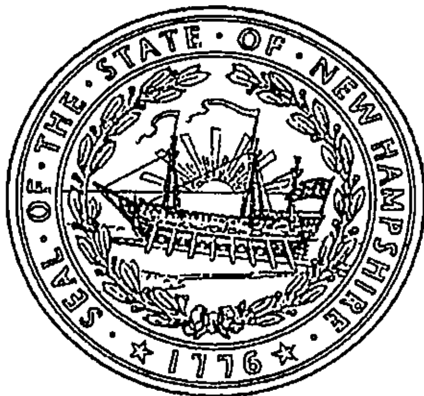
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that RANNIE WEBSTER FOUNDATION is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on December 17, 1976. 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: 63679

Certificate Number: 0005035513



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 October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Alan Gould hereby certify that:

1. I am a duly elected /Officer of Rannie Webster Foundation;

2. The following is a true copy of a vote taken at a meeting of the Board of Directors, duly called and held on December 22, 2020, at which a quorum of the Directors were present and voting.

VOTED: That Thomas Argue, CEO, and Todd Fernald, Administrator, are duly authorized on behalf of the Rannie Webster Foundation 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: 12/22/20

Signature of Elected Officer
Name: Alan Gould
Title: Vice Chairman
Rannie Webster Foundation

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2020

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
Cross Insurance-Portsmouth 75 Portsmouth Blvd. Suite 100 Portsmouth NH 03801	CONTACT NAME: Scott Wellington PHONE (A/C, No, Ext): (603) 812-2600 FAX (A/C, No): (603) 570-1073 E-MAIL ADDRESS: swellington@crossagency.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : American Alternative Ins Corp	
INSURER B : Granite State Health Care and Human Services Self-	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

Rannie Webster Foundation, DBA: Webster at Rye
795 Washington Road
Rye NH 03870

COVERAGES

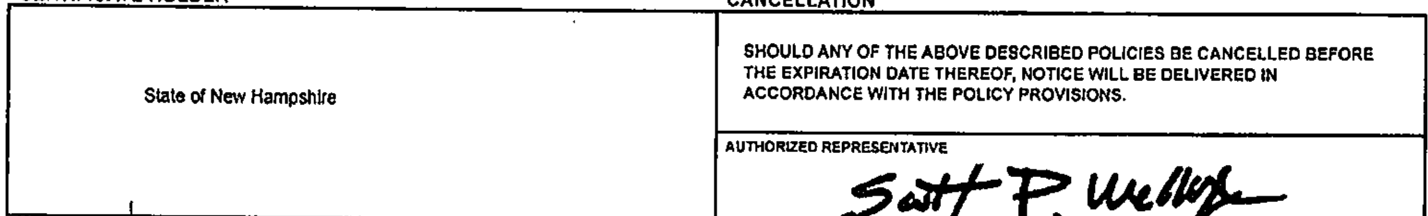
CERTIFICATE NUMBER: CL2041320092 REVISION NUMBER:

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 X CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY ☐ PRO-JECT ☐ LOC OTHER:			SLA3-NL-6150187-00	04/01/2020	04/01/2021	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Employee Benefits	$ 1,000,000 $ 1,000,000 $ 15,000 $ 1,000,000 $ 3,000,000 $ 3,000,000 $ 1,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY			SLHH-HA-1050949-00	04/01/2020	04/01/2021	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) Underinsured motorist BI	$ 1,000,000 $ $ $ $ 1,000,000
A	X UMBRELLA LIAB ☐ OCCUR EXCESS LIAB ☐ CLAIMS-MADE DED X RETENTION $ 10,000			SLA3-NE-3150128-00	04/01/2020	04/01/2021	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000 $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		HCHS20200000229	02/01/2020	02/01/2021	X 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	Professional Liability			SLG4-NL-8000016-00	04/01/2020	04/01/2021	General Aggregate Each Occurrence	3,000,000 1,000,000

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

Insurance afforded by the policies described herein is subject to all the terms, exclusions, warranties and conditions of such policies.



CERTIFICATE HOLDER	CANCELLATION
State of New Hampshire	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 Scott P. Wellington

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and ROCKINGHAM COUNTY ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,138,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

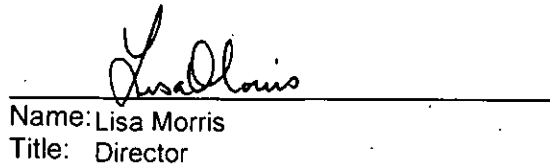
   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services



01/04/2021
Date

Name: Lisa Morris
Title: Director

ROCKINGHAM COUNTY

12/23/2020
Date

Name: Kevin St. James
Title: Chair

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $264,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 2,640 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials [initials]

Date 12/23/2020

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name: Chair

Title:

Date:

Initial [signature]

Date 12/30/2020

CERTIFICATE OF AUTHORITY

I, Kevin Coyle, Clerk, of the Rockingham County Commissioners, 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 Rockingham County.
(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 November 17, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

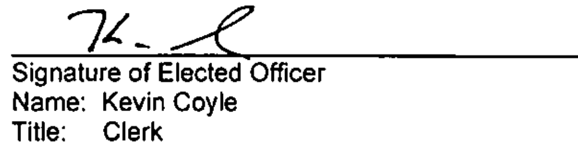
VOTED: That Kevin St. James, Chair (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Rockingham County 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: 12/01/2020



Signature of Elected Officer
Name: Kevin Coyle
Title: Clerk

CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex^3) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex^3 is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex^3 is entitled to the categories of coverage set forth below. In addition, Primex^3 may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex^3, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex^3 Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only, Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex^3. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Rockingham County 119 North Road Brentwood, NH 03833	609	NH Public Risk Management Exchange - Primex^3 Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	*Effective Date (mm/dd/yyyy)*	*Expiration Date (mm/dd/yyyy)*	*Limits - NH Statutory Limits May Apply, If Not:*	
X	**General Liability** (Occurrence Form)	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
X	**Automobile Liability** Deductible Comp and Coll: $1,000 ☐ Any auto	1/1/2020	1/1/2021	Combined Single Limit (Each Accident)	$ 5,000,000
				Aggregate	$ 5,000,000
	Workers' Compensation & Employers' Liability			☐ Statutory	
				Each Accident	
				Disease – Each Employee	
				Disease – Policy Limit	
X	**Property** (Special Risk includes Fire and Theft)	1/1/2020	1/1/2021	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: $1,000

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ **Additional Covered Party** ☐ **Loss Payee**	**Primex^3 – NH Public Risk Management Exchange**
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	**By:** *Mary Beth Purcell* **Date:** 12/2/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex^3 Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and SALEMHAVEN INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,983,500

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by: Lisa M. Morris

12/31/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

SALEMHAVEN INC

DocuSigned by: Raymond Milliard

12/30/2020
Date

Name: Raymond Milliard
Title: ceo

DocuSign Envelope ID: 04F8F9EE-ADD3-4812-B278-CC99164BBDEC

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $109,100.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,091 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials RM
Date 12/30/2020

DocuSign Envelope ID: 04F8F9EE-ADD3-4812-B278-CC99164BBDEC

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS RM

Date

12/30/2020

DocuSign Envelope ID: 04F8F9EE-ADD3-4812-B278-CC99164BBDEC

State of New Hampshire

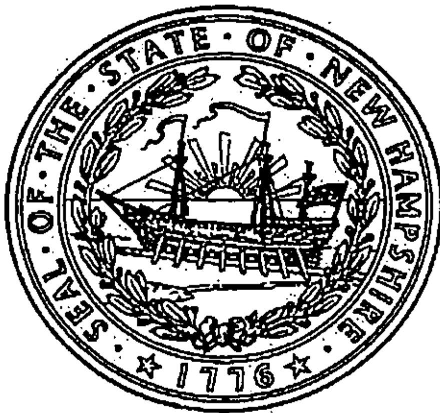
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that SALEMHAVEN, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on February 07, 1972. 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: 64360

Certificate Number: 0005045483



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 November A.D. 2020.

William M. Gardner

Secretary of State

DocuSign Envelope ID: 04F8F9EE-ADD3-4812-B278-CC99164BBDEC

CERTIFICATE OF AUTHORITY

I, ***Greg Brown***, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of ***Salemhaven, 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 December 23, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That ***Ray Millard and Brendan Stein***

are duly authorized on behalf of ***Salemhaven, 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 (120)** 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: 12/23/2020

Signature of Elected Officer

Name: Gregory Brown

Title: Secretary

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/29/2020

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
Aon Insurance Managers (Cayman) Ltd.
P.O. Box 69
18 Forum Lane, 2nd Floor
Camana Bay
Grand Cayman, Cayman Islands, . KY1-1102 .

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 : Columbia Casualty Company	31127
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Salemhaven, Inc.
23 Geremonty Drive
Salem, NH 03079

COVERAGES

CERTIFICATE NUMBER: W18501140 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:			PLC6080944759	08/09/2020	08/09/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE; OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			PLC6080944759	08/09/2020	08/09/2021	Per Event	1,000,000.00
							Aggregate	3,000,000.00

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

CERTIFICATE HOLDER

State of NH
Department of Health and Human Services
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

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SR ID: 20269754 BATCH: 1867120

DocuSign Envelope ID: 04F8F9EE-ADD3-4812-B278-CC99164BBDEC

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/05/2020

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
SANTO INSURANCE AND
224 MAIN ST STE 2A
SALEM NH 030793192
75TXL

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
SALEMHAVEN, INC. DBA
SALEMHAVEN NURSING HOME;
23 GEREMONTY DR
SALEM NH 03079-3314

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; CLAIMS-MADE; OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY; PROJECT; LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS – COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N; If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	N	(6JUB-4N98326-3-20)	06-22-20	06-22-21	X 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

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
3A:NH;

CERTIFICATE HOLDER
STATE OF NH
DHHS
129 PLEASANT ST
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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and SCHOOL STREET ASSOCIATES INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,901,600

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

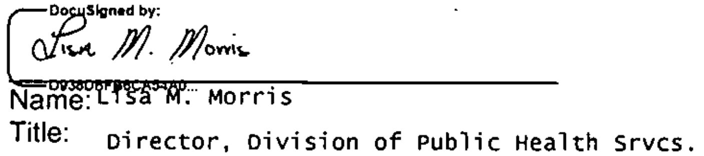
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

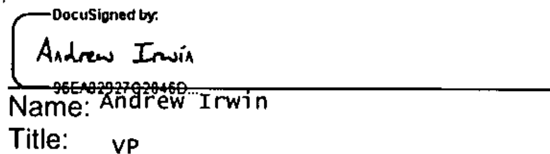
12/31/2020
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

SCHOOL STREET ASSOCIATES INC

12/30/2020
Date



Name: Andrew Irwin
Title: VP

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 27,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 272 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials AI
Date 12/30/2020

DocuSign Envelope ID: 79FFE59B-8638-45C2-B104-52A1083A0890

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS

AI

Date

12/30/2020

DocuSign Envelope ID: 79FFE59B-8638-45C2-B104-52A1083A0890

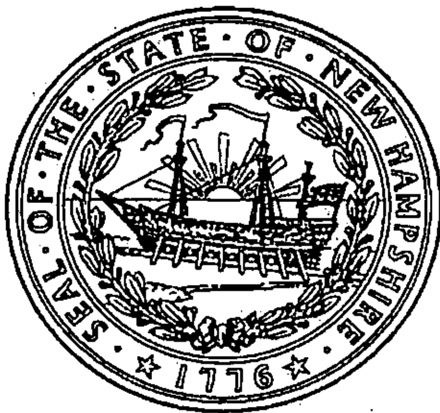
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that SCHOOL STREET ASSOCIATES, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on April 17, 1973. 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; and the attached is a true copy of the list of documents on file in this office.

Business ID: **16745**

Certificate Number: **0005032361**



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 23rd day of October A.D. 2020.

William M. Gardner

Secretary of State

CERTIFICATE OF AUTHORITY

I, David Irwin, hereby certify that:

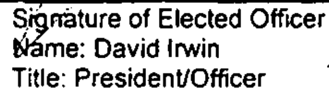
1. I am the duly elected President of School Street Associates, Inc.

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 Dec 28, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Andrew Irwin is duly authorized on behalf of School Street Associates, 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: 12/28/20



Signature of Elected Officer
Name: David Irwin
Title: President/Officer

DocuSign Envelope ID: 79FFE59B-8638-45C2-B104-52A1083A0890

SCHOSTR-01 LJUKIC

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/29/2020

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
People's United Insurance Agency, Inc.
One Financial Plaza
Hartford, CT 06103

CONTACT NAME: Anna Gallant, ACSR, CISR, CRIS
PHONE (A/C, No, Ext): (603) 399-6148 FAX (A/C, No): (603) 399-6148
E-MAIL ADDRESS: Anna.Gallant@AssuredPartners.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Ironshore Specialty Insurance Company	25445
INSURER B : Atlantic Charter Insurance Co	44326
INSURER C : Great American Assurance Co	26344
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
School Street Associates Inc. d/b/a
Hillsboro House Nursing Home
PO Box 400
Hillsboro, NH 03244

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 [ ] OCCUR [X]			002559104	11/8/2020	11/8/2021	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X Owner's & Contractor						MED EXP (Any one person)	$ 10,000
	X Professional Liabili						PERSONAL & ADV INJURY	$ Included
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	POLICY [ ] PRO-JECT [ ] LOC [ ]						PRODUCTS - COMP/OP AGG	$ Included
	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 Y/N						X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) [ ]	N/A		WCA00528509	11/8/2020	11/8/2021	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			MAC865898610	11/8/2020	11/8/2021	$1,000,000 ea claim	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Workers Compensation coverage excludes coverare for: David Irwin, AnneMarie Irwin and Andrew Irwin

CERTIFICATE HOLDER

Bureau of Contracts & Procurements
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
People's United Insurance Agency, Inc.

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The ACORD name and logo are registered marks of ACORD

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and Silverstone by Hunt ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,967,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/31/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

Silverstone by Hunt

12/28/2020
Date

DocuSigned by:
Brian Newman
Name: Brian Newman
Title: CEO

GRANT AGREEMENT EXHIBIT B

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $93,000, for the number of test listed in Exhibit A-2 – Facility List.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 test performed, during the period specified in Section 3, and will not exceed the number of staff in each facility identified in Exhibit A-2 – Facility List, Amendment #1. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials BN

Date 12/28/2020

DocuSign Envelope ID: 19B9A066-1EF9-427D-8B03-6A20B2F5E48F

Exhibit A-2, Amendment 1
Facility List

Project ID	Facility Name	Vendor Code	Address	City	State	Zip	Total TESTS	Reimbursement Amount
SS-2021-DPHS-11-LONGT-13	Hunt Community	305851	20 Plantation Dr	Jaffrey	NH	03452	448	$ 44,800.00
SS-2021-DPHS-11-LONGT-13	The Huntington at Nashua	336260	55 Kent Ln.	Nashua	NH	03062	482	$ 48,200.00
								$ 93,000.00

Grantee Initials BN

Date 12/28/2020

DocuSign Envelope ID: 19B9A066-1EF9-427D-8B03-6A20B2F5E48F

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
BN

Date

12/28/2020

DocuSign Envelope ID: 19B9A066-1EF9-427D-8B03-6A20B2F5E48F

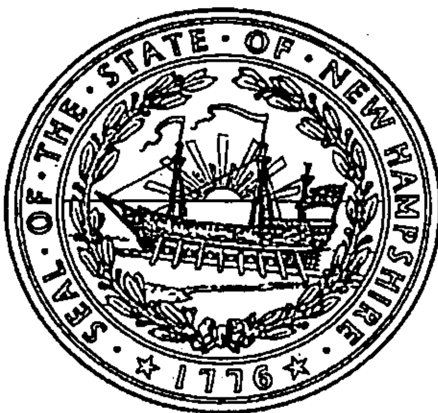
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that SILVERSTONE BY HUNT is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on June 21, 2000. 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: **349703**

Certificate Number: **0004966823**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 28th day of July A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Margaret Jaeb, 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 Silverstone by Hunt.
(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 June 23, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Brian Newman, CEO/Secretary (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Silverstone by Hunt 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: 1/4/2021

Margaret Jaeb
Signature of Elected Officer
Name: Margaret Jaeb
Title: Treasurer

DocuSign Envelope ID: 19B9A066-1EF9-427D-8B03-6A20B2F5E48F

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/3/2020

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
Fred C. Church Insurance 41 Wellman Street Lowell MA 01851	CONTACT NAME: Jenne Norton PHONE (A/C, No, Ext): 978-458-1865 FAX (A/C, No): 978-454-1865 E-MAIL ADDRESS: jnorton@fredcchurch.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Columbia Casualty Company	31127
INSURER B : A.I.M. Mutual Insurance Co	33758
INSURER C : The Continental Insurance Company	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED SILVBYH-01
SilverStone by Hunt; Hunt at Home Continuing Care;
Hunt Community; Huntington at Nashua
10 Allds Street
Nashua NH 03060-4777

COVERAGES CERTIFICATE NUMBER: 1060196164 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 X CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC OTHER:			6022608328	11/1/2020	11/1/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 3,000,000
								$
C	AUTOMOBILE LIABILITY X ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY			6022608300	11/1/2020	11/1/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	☐ UMBRELLA LIAB ☐ OCCUR X EXCESS LIAB X CLAIMS-MADE DED X RETENTION $ 0			6022608331	11/1/2020	11/1/2021	EACH OCCURRENCE	$ 4,000,000
							AGGREGATE	$ 4,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		ECC60040002052020	1/1/2020	1/1/2021	X 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
A	Professional Liability			6022608328	11/1/2020	11/1/2021	$1,000,000 $3,000,000	Each Occurrence Aggregate

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

CERTIFICATE HOLDER

SilverStone by Hunt
10 Allds Street
Nashua NH 03060

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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and ST JOSEPH RESIDENCE INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,918,200

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

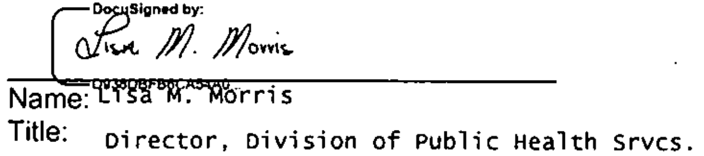
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

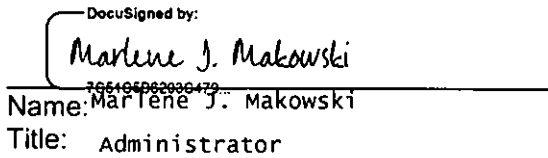
1/12/2021
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

ST JOSEPH RESIDENCE INC

12/18/2020
Date



Name: Marlene J. Makowski
Title: Administrator

DocuSign Envelope ID: 695D61D0-CC8A-47C3-A7CD-8313A3E3C36A

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 43,800.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 438 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials MJM
Date 12/18/2020

DocuSign Envelope ID: 695D61D0-CC8A-47C3-A7CD-8313A3E3C36A

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- [ ] Surveillance
- [ ] Outbreak/Response
- [ ] County rate greater than 5%
- [ ] County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

MJM

Date

12/18/2020

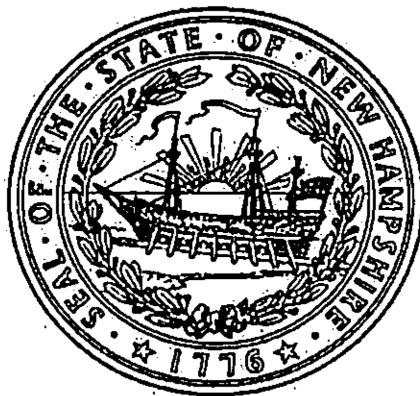
DocuSign Envelope ID: 695D61D0-CC8A-47C3-A7CD-8313A3E3C36A

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 ST. JOSEPH RESIDENCE, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 23, 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: **304367**
Certificate Number: **0005032455**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 23rd day of October A.D. 2020.

William M. Gardner
Secretary of State

DocuSign Envelope ID: 695D61D0-CC8A-47C3-A7CD-8313A3E3C36A

CERTIFICATE OF AUTHORITY

I, Sr. Marie Henault, pm, 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 St. Joseph Residence, Inc..
(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 12, 2021, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Marlene J. Makowski NHA (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Sr. Marie Henault 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: 01/12/21

Sr. Marie Henault, pm
Signature of Elected Officer
Name: Sr. Marie Henault, pm
Title: Counsilor

DocuSign Envelope ID: 695D61D0-CC8A-47C3-A7CD-8313A3E3C36A

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 7/21/2020

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
Waldorf Risk Solutions, LLC
PO Box 590
Huntington NY 11743

CONTACT NAME:
PHONE (A/C, No, Ext): 631-423-9500
FAX (A/C, No): 631-424-3610
E-MAIL ADDRESS: lauren@wrs1928.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Certain Underwriters at Lloyds, London - AA1122000	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED CONPRE
Sisters of the Presentation of Mary
209 Lawrence Street
Methuen, MA 01844

COVERAGES CERTIFICATE NUMBER: 279775429 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: [X] POLICY [ ] PRO-JECT [ ] LOC; OTHER:	Y		20W2007	7/1/2020	7/1/2021	EACH OCCURRENCE	$ 1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ Included
								$
	AUTOMOBILE LIABILITY; [ ] ANY AUTO; [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS; [ ] HIRED AUTOS ONLY [ ] 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	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Apartment Contents			20W2007	7/1/2020	7/1/2021	Sub-Limit Aggregate	30,000 100,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
RE: 495 Mammoth Road, Manchester, NH 03104 (St. Joseph's Residence)

CERTIFICATE HOLDER

Proof of Insurance

CANCELLATION 30

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
[signature]

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CATHOCHA1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/20/2020

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.

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PRODUCER	CONTACT NAME:		
USI Insurance Services LLC 3 Executive Park Drive, Suite 300 Bedford, NH 03110 855 874-0123	PHONE (A/C, No, Ext): 855 874-0123	FAX (A/C, No):	
	E-MAIL ADDRESS:		
	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A : AIM Mutual Insurance Company		33758
INSURED Catholic Charities 215 Myrtle Street Manchester, NH 03105	INSURER B :		
	INSURER C :		
	INSURER D :		
	INSURER E :		
	INSURER F :		

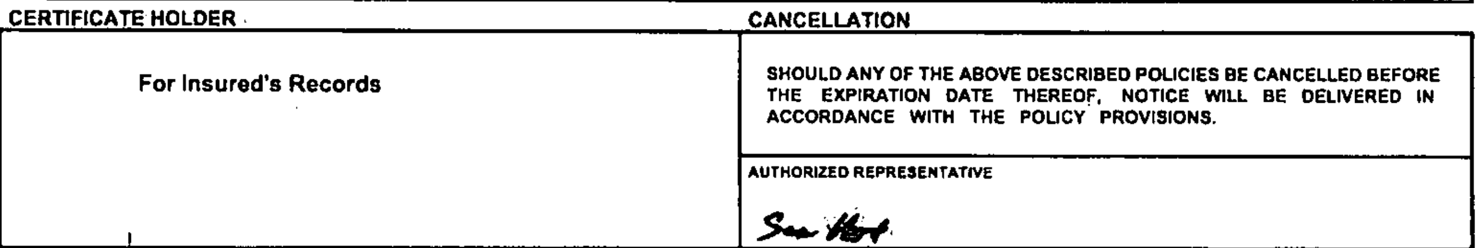
COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		ECC60040006032019A 3A States: NH	11/01/2020	11/01/2021	X 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

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

Insured: St. Joseph Residence



CERTIFICATE HOLDER	CANCELLATION
For Insured's Records	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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and STRAFFORD COUNTY NURSING HOME ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,159,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

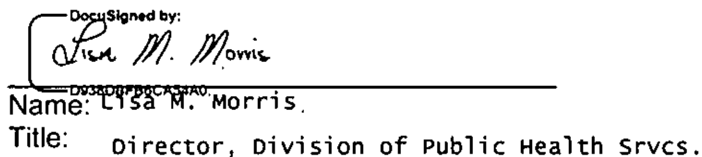
   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

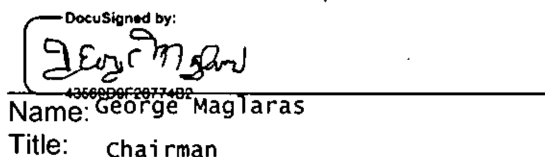
State of New Hampshire
Department of Health and Human Services



12/31/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

STRAFFORD COUNTY NURSING HOME



12/30/2020
Date

Name: George Maglaras
Title: Chairman

DocuSign Envelope ID: B73456E3-1324-4D63-8F26-FAB0FEFF79DD

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $284,600.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 2846 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials GM
Date 12/30/2020

DocuSign Envelope ID: B73456E3-1324-4D63-8F26-FAB0FEFF79DD

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
GM

Date

12/30/2020

COMMISSIONERS
GEORGE MAGLARAS, *Chairman*
ROBERT J. WATSON, *Vice Chairman*
DEANNA S. ROLLO, *Clerk*

TREASURER
PAMELA J. ARNOLD

COUNTY ADMINISTRATOR
RAYMOND F. BOWER

STRAFFORD COUNTY COMMISSIONERS

WILLIAM A. GRIMES
Justice & Administration Building
259 County Farm Road, Suite 204
Dover, New Hampshire 03820
Telephone: (603)742-1458
Fax: (603) 743-4407

CERTIFICATE OF AUTHORITY

I, Deanna S. Rollo, Clerk of the Strafford County Board of Commissioners do hereby certify that:

(1) The Strafford County Board of Commissioners voted to accept funds and enter into a contract agreement with the State of New Hampshire Department of Health and Human Services for the Long Term Care Facility COVID-19 Testing Program;
(2) The Strafford County Commissioners further authorizes the Chairman of the Board of Commissioners to execute any documents which may be necessary for this contract;
(3) This authorization has not been revoked, annulled or amended in any manner whatsoever, and remains in full force and effect as of the date hereof; and
(4) The following now occupies the office indicated above:

George Maglaras

IN WITNESS WHEREOF, I have hereunto set my hand as the Clerk this 23rd day of December 2020.

Deanna Rollo

Deanna S. Rollo, Clerk

STATE OF NEW HAMPSHIRE
COUNTY OF STRAFFORD

On this 23rd Day of December, 2020, before me Jean L. Miccolo, the undersigned officer, personally appeared Deanna S. Rollo, who acknowledged their self to be the Clerk for the Strafford County Board of Commissioners, being authorized to do so, executed the foregoing instrument for the purpose therein contained.

IN WITNESS WHEREOF, I hereunto set my and official seal.

Jean Miccolo

Notary Public
Commission Expiration Date: 12/18/2024

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CERTIFICATE OF COVERAGE

The New Hampshire Public Risk Management Exchange (Primex³) is organized under the New Hampshire Revised Statutes Annotated, Chapter 5-B, Pooled Risk Management Programs. In accordance with those statutes, its Trust Agreement and bylaws, Primex³ is authorized to provide pooled risk management programs established for the benefit of political subdivisions in the State of New Hampshire.

Each member of Primex³ is entitled to the categories of coverage set forth below. In addition, Primex³ may extend the same coverage to non-members. However, any coverage extended to a non-member is subject to all of the terms, conditions, exclusions, amendments, rules, policies and procedures that are applicable to the members of Primex³, including but not limited to the final and binding resolution of all claims and coverage disputes before the Primex³ Board of Trustees. The Additional Covered Party's per occurrence limit shall be deemed included in the Member's per occurrence limit, and therefore shall reduce the Member's limit of liability as set forth by the Coverage Documents and Declarations. The limit shown may have been reduced by claims paid on behalf of the member. General Liability coverage is limited to Coverage A (Personal Injury Liability) and Coverage B (Property Damage Liability) only. Coverage's C (Public Officials Errors and Omissions), D (Unfair Employment Practices), E (Employee Benefit Liability) and F (Educator's Legal Liability Claims-Made Coverage) are excluded from this provision of coverage.

The below named entity is a member in good standing of the New Hampshire Public Risk Management Exchange. The coverage provided may, however, be revised at any time by the actions of Primex³. As of the date this certificate is issued, the information set out below accurately reflects the categories of coverage established for the current coverage year.

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 coverage categories listed below.

Participating Member:	*Member Number:*	*Company Affording Coverage:*
Strafford County 259 County Farm Road Dover, NH 03820	605	NH Public Risk Management Exchange - Primex³ Bow Brook Place 46 Donovan Street Concord, NH 03301-2624

	Type of Coverage	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Limits - NH Statutory Limits May Apply, If Not:	
X	General Liability (Occurrence Form)	1/1/2020	1/1/2021	Each Occurrence	$ 5,000,000
	Professional Liability (describe) ☐ Claims Made ☐ Occurrence			General Aggregate	$ 5,000,000
				Fire Damage (Any one fire)	
				Med Exp (Any one person)	
	Automobile Liability Deductible Comp and Coll: ☐ Any auto			Combined Single Limit (Each Accident)	
				Aggregate	
X	Workers' Compensation & Employers' Liability	1/1/2020	1/1/2021	X Statutory	$2,000,000
				Each Accident	$2,000,000
				Disease – Each Employee	
				Disease – Policy Limit	
	Property (Special Risk includes Fire and Theft)			Blanket Limit, Replacement Cost (unless otherwise stated)	

Description: Proof of Primex Member coverage only.

CERTIFICATE HOLDER: ☐ Additional Covered Party ☐ Loss Payee	Primex³ – NH Public Risk Management Exchange
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	By: *Mary Beth Purcell* Date: 10/27/2020 mpurcell@nhprimex.org Please direct inquires to: **Primex³ Claims/Coverage Services** **603-225-2841 phone** **603-228-3833 fax**

Primex³ Contract Review

Member Name: Strafford County

Title of Contract: COVID-19 Grant Agreement (NH DHHS)

Member Contact: Diane Legere

Date: October 27, 2020

Dear Diane,

Thank you very much for sending us your contract for review and feedback. By working together, we can hopefully improve the contract's alignment with coverage and minimize your assumption of liability. Our review, as your pooled coverage provider, is specifically focused on language that transfers liabilities through indemnification clauses, additional insured certificates and waivers of rights, such as our right to recoup loss payments on your behalf through subrogation. In addition to considering our feedback, we strongly recommend that you review the contract in its entirety with your legal counsel. We have included below language from our insuring document that explains the scope and limits of coverage available for your contractual promises to defend and indemnify third parties. Our recommendations provided on this form do not increase or decrease the coverage available for contractual liability.

Recommendations:

The indemnification obligation in section 14 can be triggered by the acts or omissions of fund recipients and subcontractors which is not ideal. Beginning on the fifth line of section 14 and ending on the sixth line, it is recommended to strike "or subcontractor, or subgrantee or other agent of the Grantee."

Thank you,

Amy Poole

Contractual Liability (assumption of liability)	**$1,000,000 per written contract to assume liability of third party** **$1,000,000 aggregate for the policy period**

Under no circumstances shall there be coverage for your contractual obligations to defend, hold harmless or indemnify; i.e., assume liability, for: (1) architects, engineers or surveyors, or any of their business entities, employers, employees, contractors, subcontractors or agents; (2) your employees or officials; and (3) any person or entity with respect to any occurrences, incidents or events that transpired before you assumed the contractual liability to defend, indemnify or hold harmless such person or entity.

However, we will cover certain contractual assumptions of liability to defend, indemnify or hold harmless a third party subject to the following terms and conditions. Our coverage of a written contractual obligation of a Member or covered entity to assume liability for; i.e. defend, indemnify or hold harmless, a third party shall be (1) subject to and limited by all terms, conditions, exclusions and the specific Contractual Liability sublimit set forth in the Public Entity Coverage Documents and Declarations; (2) limited to bodily injury and property damage claims under Coverage A, Personal Injury Liability, and Coverage B, Property Damage Liability; and (3) not in addition to or stacked upon any coverage we have extended to the third party through an Additional Covered Party certificate under Amendment #3.

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and TAYLOR COMMUNITY ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

    1.8 Grant Amount not to exceed: $2,029,800

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

    1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

    1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

    1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

    1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

    1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

    1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

    1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

    1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/12/2021
Date

DocuSigned by:
Lisa M. Morris
D930DBEB6CA5440...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

TAYLOR COMMUNITY

1/11/2021
Date

DocuSigned by:
Michael Flaherty
Name: Michael Flaherty
Title: President and CEO

DocuSign Envelope ID: E2766A3B-03E2-4512-B0FC-8F47DB44A42E

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $155,400.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 1,554 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials MF

Date 1/11/2021

DocuSign Envelope ID: E2766A3B-03E2-4512-B0FC-8F47DB44A42E

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
MF

Date

1/11/2021

DocuSign Envelope ID: E2766A3B-03E2-4512-B0FC-8F47DB44A42E

State of New Hampshire

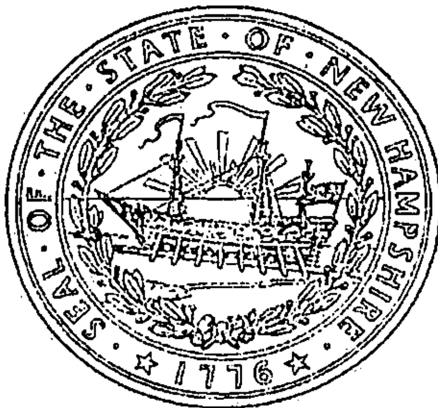
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that TAYLOR COMMUNITY is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on March 14, 1907. 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: 66900

Certificate Number: 0005030620



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 20th day of October A.D. 2020.

William M. Gardner

Secretary of State

DocuSign Envelope ID: E2766A3B-03E2-4512-B0FC-8F47DB44A42E

CERTIFICATE OF AUTHORITY

I, Ronald Baker, hereby certify that:

1. I am a duly elected Clerk/Secretary/Officer of Taylor Community.

2. The following is a true copy of a vote taken at a meeting of the Board of Trustees/shareholders, duly called and held on October 27, 2020 at which a quorum of the Trustees/shareholders were present and voting.

   VOTED: Michael Flaherty, President and Chief Executive Officer is duly authorized on behalf of Taylor Community 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 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 ninety (90) 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 in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: JANUARY 8, 2021

Ronald A Baker
Signature of Elected Officer
Name: RONALD A. BAKER
Title: TREASURER

DocuSign Envelope ID: E2766A3B-03E2-4512-B0FC-8F47DB44A42E

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2020

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
Melcher & Prescott Insurance
426 Main Street
Laconia NH 03246

CONTACT NAME: Jill Martineau
PHONE (A/C, No, Ext): (603) 524-4535
FAX (A/C, No):
E-MAIL ADDRESS: jmartineau@melcher-prescott.com

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Cincinnati Insurance Co.	
INSURER B :	NH Employers Insurance Co.	13083
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
Taylor Community
435 Union Avenue
Laconia NH 03246

COVERAGES CERTIFICATE NUMBER: CL20102105897 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:			HCF0008520	05/01/2020	05/01/2021	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
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
							Cosmetologist	$ 1,000,000
A	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY			HFA0006417	05/01/2020	05/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Underinsured motorist	$ 1,000,000
A	[X] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $			HCF0008520	05/01/2020	05/01/2021	EACH OCCURRENCE	$
							AGGREGATE	$
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WMZ80080069372020A	10/01/2020	10/01/2021	[X] 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

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

CERTIFICATE HOLDER

State of NH, Department of Health & Human Services
129 Pleasant St
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

Jill M. Martineau

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and THE COURVILLE AT NASHUA, INC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,938,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

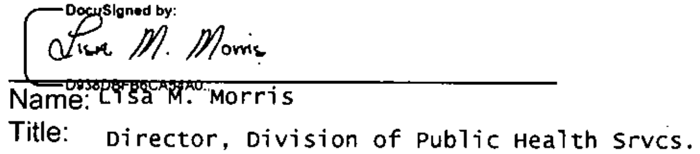
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

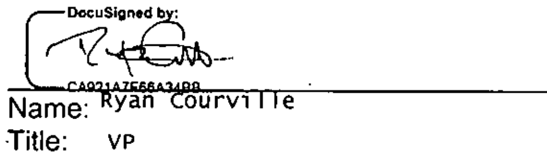
12/22/2020
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

THE COURVILLE AT NASHUA, INC

12/22/2020
Date



Name: Ryan Courville
Title: VP

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $64,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 640 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

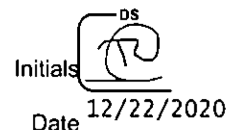
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.



Initials
Date 12/22/2020

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New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS

Date

12/22/2020

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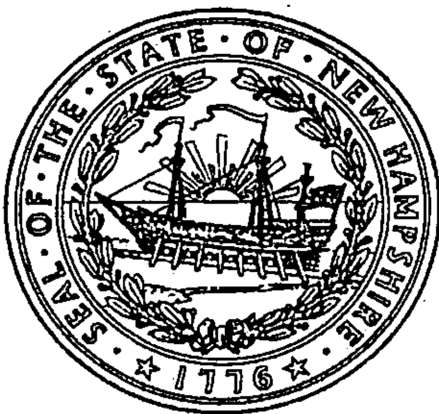
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that THE COURVILLE AT NASHUA, INC. is a New Hampshire Profit Corporation registered to transact business in New Hampshire on March 10, 1980. 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: 10404

Certificate Number: 0005031517



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 21st day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY
OF
THE COURVILLE AT NASHUA, INC.

I, the undersigned, Richard G. Courville, as Secretary of The Courville at Nashua, Inc., a New Hampshire corporation, hereby certifies that:

1. I am a duly elected Secretary of The Courville at Nashua, Inc.

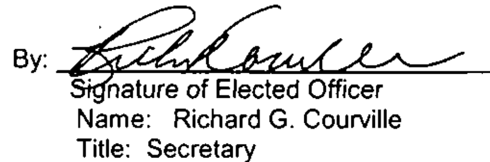
2. The following is a true copy of a resolution duly adopted by consent resolutions in lieu of a meeting of the sole Director of The Courville at Nashua, Inc. on December 22, 2020.

RESOLVED: That Ryan Courville ("Mr. Ryan Courville"), as Vice President of The Courville at Nashua, Inc., is duly authorized on behalf of The Courville at Nashua, Inc., to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and that Mr. Ryan Courville is further authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may, in his judgment, be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said resolution 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 of Authority as evidence that the person listed above currently occupies the position indicated and that he has full authority to bind The Courville at Nashua, Inc. 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: December 22, 2020

The Courville at Nashua, Inc.

By: 

Signature of Elected Officer
Name: Richard G. Courville
Title: Secretary

DocuSign Envelope ID: C106582B-FA0A-4FA3-8F46-A8FB33177D72

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/07/2020

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

Cross Insurance - Lewiston
150 Mill Street
Fourth Floor, Suite 4
Lewiston ME 04240-3101

CONTACT NAME: Susan Dwelley
PHONE (A/C, No, Ext): (207) 783-8591
FAX (A/C, No): (207) 783-3852
E-MAIL ADDRESS: sdwelley@crossagency.com

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Medical Mutual Ins Company of Maine	
INSURER B :	Massachusetts Bay Ins Co	22306
INSURER C :	AmGuard Ins Co	42390
INSURER D :		
INSURER E :		
INSURER F :		

INSURED

The Courville Company, Inc.
175 River Road
Manchester NH 03104

COVERAGES CERTIFICATE NUMBER: CL205721901 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 [X] $5,000 Each Event Ded/$25K Agg GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC OTHER:			NHNHL002265	05/01/2020	05/01/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
							Professional Liab - Each	$ 1,000,000
B	AUTOMOBILE LIABILITY [X] ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			ADP2868404	05/01/2020	05/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Medical payments	$ 5,000
A	[X] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [X] CLAIMS-MADE [ ] DED [X] RETENTION $ 10,000			NHUMB004470	05/01/2020	05/01/2021	EACH OCCURRENCE	$ 9,000,000
							AGGREGATE	$ 9,000,000
								$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		COWC196561	05/01/2020	05/01/2021	[X] PER STATUTE [ ] OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
A	Prof Liab-Claims Made; 5/1/20 Retro $5,000 each loss ded / $25K agg ded			NHNHL002265	05/01/2020	05/01/2021	Each Loss Limit	1,000,000
							Aggregate Limit	3,000,000

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

Supplemental Name:

The Courville Company
The Courville Company at Nashua, Inc. & The Villas at Nashua, Inc.
The Courville at Manchester
Carlysle Place
Aynsley Place

CERTIFICATE HOLDER

State of New Hampshire Department of Health & Human
Office of Operations Support
129 Pleasant St.
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

Susan M. Dwelley

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AGENCY CUSTOMER ID: 00038075

LOC #:

ADDITIONAL REMARKS SCHEDULE

Page ___ of ___

AGENCY Cross Insurance - Lewiston		NAMED INSURED The Courville Company, Inc.
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

RE: Surveyors

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Additional Named Insureds

Other Named Insureds

175 North River Road, LLC	Additional Named Insured
Aynsley Place Inc.	Additional Named Insured
Carlyle Place Inc.	Additional Named Insured
Courville Succession Trust	Additional Named Insured
FAS Master, LLC	
La Quinta I Holdings Inc.	Additional Named Insured
La Quinta II Holdings Inc.	Additional Named Insured
Ole Blue Eyes - Manchester, LLC	Additional Named Insured
Pond Haven Associates Limited Partnership	Additional Named Insured
Summer Wind - Nashua, LLC	Additional Named Insured
TCN Realty Limited Partnership	Additional Named Insured
The Courville at Manchester LLC	Additional Named Insured
The Courville at Nashua Inc.	Additional Named Insured
The Villas at Nashua LLC	Additional Named Insured

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and THE COURVILLE AT MANCHESTER, LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,938,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

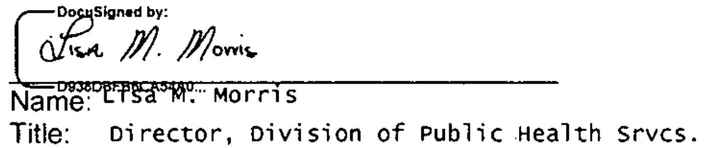
3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

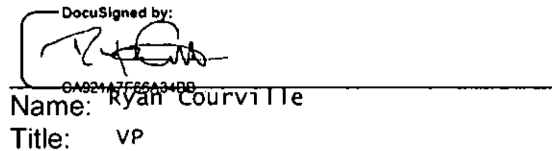
12/22/2020
Date



Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

THE COURVILLE AT MANCHESTER, LLC

12/22/2020
Date



Name: Ryan Courville
Title: VP

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $64,000.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 640 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

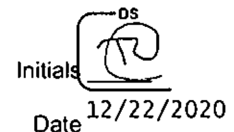
4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials 

Date 12/22/2020

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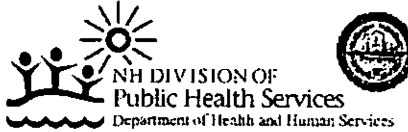


New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS

Date

12/22/2020

DocuSign Envelope ID: 6CD2450F-EA0B-4C5A-AF9A-446190BA306A

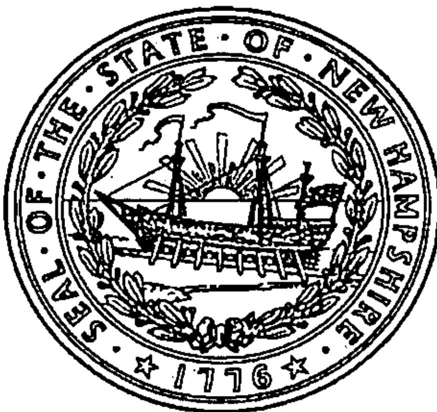
State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that THE COURVILLE AT MANCHESTER, L.L.C. is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on October 06, 1994. 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: **218046**

Certificate Number: **0005031516**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 21st day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY
OF
THE COURVILLE AT MANCHESTER, L.L.C.

I, the undersigned, Richard G. Courville, as President of La Quinta Holdings I, Inc., a New Hampshire corporation and the Manager of The Courville at Manchester, L.L.C., a New Hampshire limited liability company, hereby certifies that:

1. I am a duly elected President of La Quinta Holdings I, Inc., the Manager of The Courville at Manchester, L.L.C.

2. The following is a true copy of a resolution duly adopted by consent resolutions in lieu of a meeting of the Manager of The Courville at Manchester, L.L.C. on December 22, 2020.

RESOLVED: That Ryan Courville ("Mr. Ryan Courville"), as Vice President of La Quinta Holdings I, LLC, the Manager of The Courville at Manchester, L.L.C., is duly authorized on behalf of La Quinta Holdings I, LLC, as the Manager of The Courville at Manchester, L.L.C., to enter into contracts or agreements with the State of New Hampshire and any of its agencies or departments and that Mr. Ryan Courville is further authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may, in his judgment, be desirable or necessary to effect the purpose of this vote.

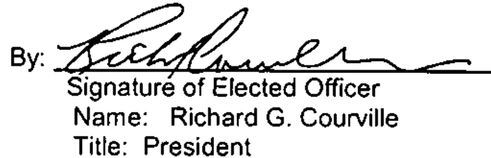
3. I hereby certify that said resolution has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this Certificate of Authority as evidence that the person listed above currently occupies the position indicated and that he has full authority to bind La Quinta Holdings I, LLC, as the Manager of The Courville at Manchester, L.L.C. 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: December 22, 2020

The Courville at Manchester, L.L.C.

By:

La Quinta Holdings I, Inc., its Manager

By: 
Signature of Elected Officer
Name: Richard G. Courville
Title: President

DocuSign Envelope ID: 6CD2450F-EA0B-4C5A-AF9A-446190BA306A

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/07/2020

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: Susan Dwelley	
Cross Insurance - Lewiston	PHONE (A/C, No, Ext): (207) 783-8591	FAX (A/C, No): (207) 783-3852
150 Mill Street	E-MAIL ADDRESS: sdwelley@crossagency.com	
Fourth Floor, Suite 4	INSURER(S) AFFORDING COVERAGE	NAIC #
Lewiston ME 04240-3101	INSURER A: Medical Mutual Ins Company of Maine	
INSURED	INSURER B: Massachusetts Bay Ins Co	22306
The Courville Company, Inc.	INSURER C: AmGuard Ins Co	42390
175 River Road	INSURER D:	
	INSURER E:	
Manchester NH 03104	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL205721901 **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; X $5,000 Each Event Ded/$25K Agg; GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY; PRO-JECT; LOC; OTHER:			NHNHL002265	05/01/2020	05/01/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
							Professional Liab - Each	$ 1,000,000
B	AUTOMOBILE LIABILITY; X ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; X HIRED AUTOS ONLY; X NON-OWNED AUTOS ONLY			ADP2868404	05/01/2020	05/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
							Medical payments	$ 5,000
A	X UMBRELLA LIAB; OCCUR; EXCESS LIAB; X CLAIMS-MADE; DED; X RETENTION $ 10,000			NHUMB004470	05/01/2020	05/01/2021	EACH OCCURRENCE	$ 9,000,000
							AGGREGATE	$ 9,000,000
								$
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		COWC196561	05/01/2020	05/01/2021	X PER STATUTE; OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
A	Prof Liab-Claims Made; 5/1/20 Retro $5,000 each loss ded / $25K agg ded			NHNHL002265	05/01/2020	05/01/2021	Each Loss Limit	1,000,000
							Aggregate Limit	3,000,000

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

Supplemental Name:

The Courville Company
The Courville Company at Nashua, Inc. & The Villas at Nashua, Inc.
The Courville at Manchester
Carlysle Place
Aynsley Place

CERTIFICATE HOLDER	CANCELLATION
State of New Hampshire Department of Health & Human Office of Operations Support 129 Pleasant St. Concord NH 03301	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 Susan M. Dwelley

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AGENCY CUSTOMER ID: 00038075

LOC #:

ADDITIONAL REMARKS SCHEDULE

Page ___ of ___

AGENCY		NAMED INSURED
Cross Insurance - Lewiston		The Courville Company, Inc.
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

RE: Surveyors

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Additional Named Insureds

Other Named Insureds	
175 North River Road, LLC	Additional Named Insured
Aynsley Place Inc.	Additional Named Insured
Carlyle Place Inc.	Additional Named Insured
Courville Succession Trust	Additional Named Insured
FAS Master, LLC	
La Quinta I Holdings Inc.	Additional Named Insured
La Quinta II Holdings Inc.	Additional Named Insured
Ole Blue Eyes - Manchester, LLC	Additional Named Insured
Pond Haven Associates Limited Partnership	Additional Named Insured
Summer Wind - Nashua, LLC	Additional Named Insured
TCN Realty Limited Partnership	Additional Named Insured
The Courville at Manchester LLC	Additional Named Insured
The Courville at Nashua Inc.	Additional Named Insured
The Villas at Nashua LLC	Additional Named Insured

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and THE MORRISON HOSPITAL ASSOCIATION ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,940,600

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. ≤5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:
Lisa M. Morris

12/21/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

THE MORRISON HOSPITAL ASSOCIATION

DocuSigned by:
Louise Belanger

12/21/2020
Date

Name: Louise Belanger
Title: Executive Director

New Hampshire Department of Health and Human Services
Long Term Care Facility COVID-19 Testing Program

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 66,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 662 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials LB

Date 12/21/2020

DocuSign Envelope ID: 0A0CF587-040B-487E-B8FE-6CB9EC208238

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
LB

Date

12/21/2020

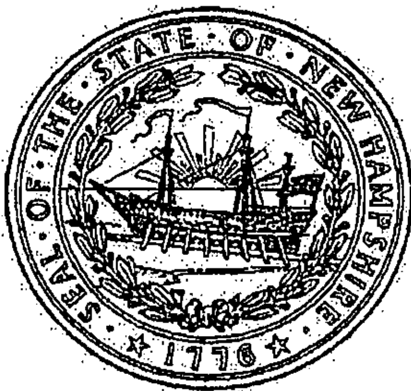
DocuSign Envelope ID: 0A0CF587-040B-487E-B8FE-6CB9EC208238

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 MORRISON HOSPITAL ASSOCIATION is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on April 22, 1927. 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: **62982**
Certificate Number: **0005030515**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 20th day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Douglas A. Shearer, President, 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 Morrison Hospital Association.
(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 Feb 28th, 2019, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Louise Belanger, Executive Director (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Morrison Hospital Assoc. 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: 12/22/2020

Douglas A. Shearer
Signature of Elected Officer
Name: Douglas A. Shearer
Title: President.

DocuSign Envelope ID: 0A0CF587-040B-487E-B8FE-6CB9EC208238

ACORD

MORRNUR-01 DRIOUX

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/21/2020

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
Eaton & Berube Insurance Agency, LLC.
11 Concord Street
Nashua, NH 03064

CONTACT NAME: Deborah Rioux
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS: drioux@eatonberube.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Ins Co of Maine	36277
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Morrison Hospital Association DBA Morrison Nursing Home
6 Terrace Street
Whitefield, NH 03598

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; GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY; PRO-JECT; LOC; OTHER:			NHNHL002394	5/23/2020	5/23/2021	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
							GENERAL AGGREGATE	$ 3,000,000
							PRODUCTS - COMP/OP AGG	$ 1,000,000
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional			NHNHL002394	5/23/2020	5/23/2021	Each Claim	1,000,000
A	Liability			NHNHL002394	5/23/2020	5/23/2021	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 Dept. 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
David Stowe

ACORD 25 (2016/03)

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ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/16/2020

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
Hamilton Insurance Agency
4100 Monument Corner Dr. #500
Fairfax VA 22030

CONTACT NAME:
PHONE (A/C, No, Ext): 703-359-8100 | FAX (A/C, No): 703-359-8108
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : A.I.M. Mutual Insurance Compan	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED THEMO-1
Morrison Hospital Association dba
Morrison Nursing Home
6 Terrace Street
Whitefield NH 03598

COVERAGES CERTIFICATE NUMBER: 743535981 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; CLAIMS-MADE; OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY; PRO-JECT; LOC; OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC-600-4000156-2021A	1/1/2021	1/1/2022	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

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Location: Morrison Hospital Association dba Morrison Nursing Home
Location 1: 6 Terrace Street, Whitefield, NH 03598
Location 2: 56 Summit Drive, Whitefield, NH 03598

CERTIFICATE HOLDER

Evidence of Insurance

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

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MORRHOS-01 TERESAD

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/21/2020

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:		
Hunkins & Eaton Agency Inc 93 Main Street Littleton, NH 03561	PHONE (A/C, No, Ext): (603) 444-3975	FAX (A/C, No): (603) 444-1131	
	E-MAIL ADDRESS:		
	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A : Philadelphia Insurance Companies		23850
INSURED	INSURER B :		
Morrison Hospital Association 6 Terrace St Whitefield, NH 03598	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 CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY X SCHEDULED AUTOS X HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY			PHPK2134409	5/23/2020	5/23/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Property			PHPK2134409	5/23/2020	5/23/2021	Buildings & BPP	26,090,424

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Nursing Home & Assisted Living Facilities

CERTIFICATE HOLDER	CANCELLATION
NH Department of Health & Human Services 129 Pleasant St Concord, NH 03301	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 Teresa A Dodge

ACORD 25 (2016/03)

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and THE PROSPECT WOODWARD HOME ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,929,000

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/23/2020
Date

DocuSigned by:
Lisa M. Morris
D938DBFB8CA54A0
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

THE PROSPECT WOODWARD HOME

12/21/2020
Date

DocuSigned by:
Mary Ellen Dunham
41D8E4B27CA348C
Name: Mary Ellen Dunham
Title: Administrator

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 54,600.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 546 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DS
Initials MED
Date 12/21/2020

DocuSign Envelope ID: 01492097-E6DE-47E1-8353-AAC92C654EF0

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
MED

Date

12/21/2020

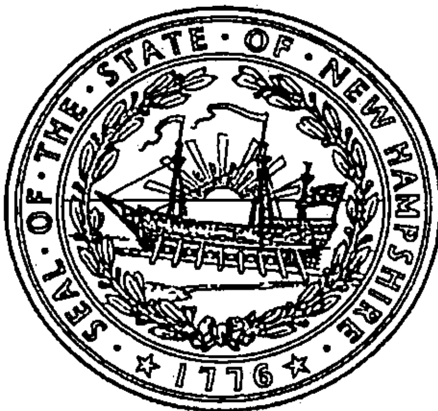
DocuSign Envelope ID: 01492097-E6DE-47E1-8353-AAC92C654EF0

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 THE PROSPECT-WOODWARD HOME is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on March 15, 1951. 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: **68668**
Certificate Number: **0005032086**



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 22nd day of October A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Rand S. Burnett, hereby certify that:

1. I am the duly elected Secretary of The Prospect-Woodward Home.

2. The following is a true copy of a vote taken at a meeting of the Board of Directors, duly called and held on October 28, 2020, at which a quorum of the Directors were present and voting.

VOTED: That Mary Ellen Dunham, Health Center Administrator,

is duly authorized on behalf of The Prospect-Woodward Home to enter into the COVID-19 Grant Agreement (in connection with the Long Term Care Facility COVID-19 Testing Program) with the State of New Hampshire and any of its agencies or departments and further is authorized to execute said COVID-19 Grant Agreement and 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: December 31, 2020

Signature of Elected Officer
Name: Rand S. Burnett
Title: Secretary

DocuSign Envelope ID: 01492097-E6DE-47E1-8353-AAC92C654EF0

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/5/2020

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
Arthur J. Gallagher Risk Management Services, Inc.
2850 Golf Road
Rolling Meadows IL 60008

CONTACT NAME:
PHONE (A/C, No, Ext): 312-704-0100 | FAX (A/C, No): 312-803-7443
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Zurich American Insurance Company	16535
INSURER B : Ironshore Specialty Insurance Co	25445
INSURER C : Hiscox Insurance Company Inc.	10200
INSURER D :	
INSURER E :	
INSURER F :	

INSURED LCSHOLD-03
Hillside Village Keene
The Prospect-Woodward Home
95 Wyman Road
Keene NH 03431

COVERAGES CERTIFICATE NUMBER: 1323708353 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	
B	X COMMERCIAL GENERAL LIABILITY			004052801	6/30/2020	6/30/2021	EACH OCCURRENCE	$ 1,000,000
	X CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
	X Policy Agg:						MED EXP (Any one person)	$ 10,000
	X $27,500,000						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 3,000,000
	☐ POLICY ☐ PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$ 3,000,000
	OTHER:						Deductible	$ 0
A	AUTOMOBILE LIABILITY			BAP 4192983-02	6/30/2020	6/30/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X 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)	$
	X CompDed:$500 X CollDed:$500							$
B	X UMBRELLA LIAB ☐ OCCUR			004053001	6/30/2020	6/30/2021	EACH OCCURRENCE	$ 10,000,000
	☐ EXCESS LIAB X CLAIMS-MADE						AGGREGATE	$ 50,000,000
	DED ☐ RETENTION $						Facility Agg	$ 10,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			WC4192984-02	6/30/2020	6/30/2021	X PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBEREXCLUDED? (Mandatory in NH) ☐	N/A					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 B	Crime Prof Liab (Claims Made)			UC24457814.20 004052801	6/30/2020 6/30/2020	6/30/2021 6/30/2021	Limit of Liability Per Claim Aggregate	$3,000,000 $1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
PROFESSIONAL LIABILITY DEDUCTIBLE IS SAME AS GL DEDUCTIBLE. The General Liability policy includes TRIA coverage.

CERTIFICATE HOLDER

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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and The Riverwoods Group ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $2,147,100

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/4/2021
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

The Riverwoods Group

1/4/2021
Date

DocuSigned by:
Justine Vogel
Name: Justine Vogel
Title: CEO

Exhibit A-2, Amendment 1

Facility List

Facility Name	Vendor (	Total TESTS	Reimbursement Amount	
Birch Hill - The Manor	336365	684	$	68,400.00
RiverWoods - Boulders - Winnisquam Lodge	336365	684	$	68,400.00
RiverWoods - Woods - Monadnock Lodge	336365	675	$	67,500.00
RiverWoods Ridge - Suncook Lodge	336365	684	$	68,400.00
			$	272,700.00

Grantee Initials JV

Date 1/4/2021

GRANT AGREEMENT EXHIBIT B

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $272,700, for the number of test listed in Exhibit A-2 – Facility List.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 test performed, during the period specified in Section 3, and will not exceed the number of staff in each facility identified in Exhibit A-2 – Facility List, Amendment #1. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials JV
Date 1/4/2021

DocuSign Envelope ID: 15E601A7-1847-4841-A6AB-7836C1A02165

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	**Week 2 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 3 Test Date	**Week 3 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 4 Test Date	**Week 4 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	
Week 5 Test Date (if applicable)	**Week 5 Second Test Date (if applicable)**	**Total Staff Tested**	**Residents Tested (if applicable)**	**Rate**	**Reimbursement Amount**
				$100/Test	

Name

Title

DS
JV

Date

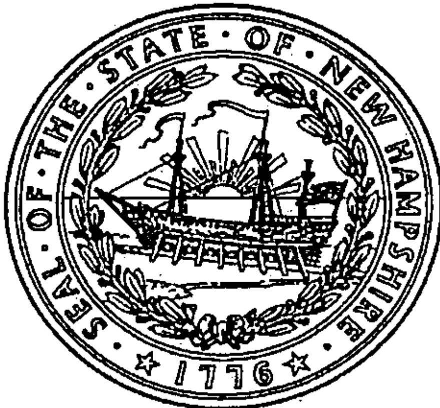
1/4/2021

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 THE RIVERWOODS GROUP is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on February 17, 2011. 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: **644039**
Certificate Number: **0005068032**



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 January A.D. 2021.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, ____________________Beth Roberts____, 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 The RiverWoods Group.
(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 4, 2021, at which a quorum of the Directors/shareholders were present and voting.
(Date)

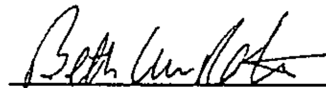
VOTED: That Justine Vogel, CEO and TRWG Board Clerk (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of __________ The RiverWoods Group ________ 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:___1/4/2021



Signature of Elected Officer
Name: Beth Roberts
Title: TRWG Board Chair

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/05/2021

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 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
Caring Communities Shared Services LTD
1850 W. Winchester Road
Suite 109
Libertyville IL 60048

CONTACT NAME: Underwriting Associate
PHONE (A/C, No, Ext): 847-549-8225 FAX (A/C, No): 847-549-8095
E-MAIL ADDRESS: Certificates@caringcomm.org

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Caring Communities, A Reciprocal RRG	12373
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

INSURED The RiverWoods Company at Exeter, New Hampshire
The RiverWoods Company at Exeter, New Hampshire
5 White Oak Drive
Exeter NH 03833

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	ADD'L INSR	SUBR WVD	POLICY NUMBER	POLICY EFF	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS MADE [X] OCCUR X PL/ML–Claims Made GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY / PRO-JECT / LOC OTHER:			CCRRRG-0040-21 Includes Management Liability (EPLI, D&O & Fiduciary	01/01/2021	01/01/2022	EACH OCCURRENCE	$ 1,000,000.00
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000.00
							MED EXP (Any one person)	$ -
							PERSONAL & ADV INJURY	$ 1,000,000.00
							GENERAL AGGREGATE	$ 3,000,000.00
							PRODUCTS - COMP/OP AGG	$ incl
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	UMBRELLA LIAB [X] OCCUR-GL X EXCESS LIAB [X] CLAIMS MADE-PL/ML DEDUCTIBLE RETENTION $			CCRRRG-0040-21 *Sublimits apply	01/01/2021	01/01/2022	EACH OCCURRENCE PL/GL	$ 10,000,000.00
							AGGREGATE PL/GL	$ 10,000,000.00
							*AUTO	$ 6,000,000.00
							*EMP BEN	$ 5,000,000.00
							EPLI/D&O (Occur&Aggr)	$ 5,000,000.00
							*FIDUCIARY (Occur&Aggr)	$ 5,000,000.00
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
	OTHER							

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
12/21/2020 10:57:03

CERTIFICATE HOLDER
The RiverWoods Company at Exeter, New Hampshire
5 White Oak Drive
Exeter NH 03833

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

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 1/4/2021

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
Fred C. Church Insurance
41 Wellman Street
Lowell MA 01851

CONTACT NAME: Donna Harder
PHONE (A/C, No, Ext): 800-225-1865 FAX (A/C, No): 978-454-1865
E-MAIL ADDRESS: dharder@fredcchurch.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Continental Casualty Company	20443
INSURER B : A.I.M. Mutual Insurance Co	33758
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED RIVEGRO-01
The RiverWoods Group
5 White Oak Drive
Exeter NH 03833

COVERAGES CERTIFICATE NUMBER: 330691954 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; CLAIMS-MADE / OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC; OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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 Y/N; ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		8007799	1/1/2021	1/1/2022	PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$ 500,000
							E.L. DISEASE - EA EMPLOYEE	$ 500,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000
A	Property Agreed Amount Repl Cost			RMP6014897220	11/1/2020	11/1/2021	Blanket Bldg & Cnts Blanket Business Inc Ded AOP/Water	200,000,000 48,067,000 50,000 / 100,000

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

CERTIFICATE HOLDER

NH Department of Health & Human Services
129 Pleasant Street, Brown Building
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

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and UNITED CHURCH OF CHRIST RETIREMENT COMMUNITY ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

    1.8 Grant Amount not to exceed: $2,085,600

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

    1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

    1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

    1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

    1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

    1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

    1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

    1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

    1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

12/31/2020
Date

DocuSigned by:
Lisa M. Morris
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

UNITED CHURCH OF CHRIST RETIREMENT COMMUNITY

12/31/2020
Date

DocuSigned by:
Michael Palmieri
Name: Michael Palmieri
Title: President/CEO

DocuSign Envelope ID: D2552603-A6C4-42AA-B086-C2E7C53C8670

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $211,200.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 2,112 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials MP

Date 12/31/2020

DocuSign Envelope ID: D2552603-A6C4-42AA-B086-C2E7C53C8670

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:

2) How many staff members does your facility have?

3) Staff testing lab utilized:

4) Reimbursement type (please check all that apply):

- ☐ Surveillance
- ☐ Outbreak/Response
- ☐ County rate greater than 5%
- ☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)

6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS MP

Date

12/31/2020

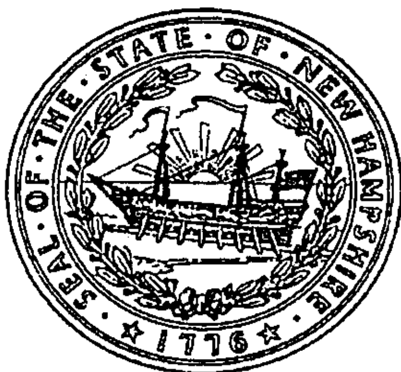
DocuSign Envelope ID: D2552603-A6C4-42AA-B086-C2E7C53C8670

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 THE UNITED CHURCH OF CHRIST RETIREMENT COMMUNITY, INC. is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on April 18, 1966. 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: 65625
Certificate Number: 0005024744



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 7th day of October A.D. 2020:

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Anna Marie Sparks, 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 The United Church of Christ Retirement Community, Inc. D/B/A Havenwood Heritage Heights
(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 October 21, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: Michael A. Palmieri, President/CEO (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of The United Church of Christ Retirement Community Inc. D/B/A Havenwood Heritage Heights 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: 12/3/20

[signature]
Signature of Elected Officer
Name: Anna Marie Sparks
Title: Secretary

Client#: 491851 UCCRCINC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/21/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
3 Executive Park Drive, Suite 300
Bedford, NH 03110
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : AIX Specialty Insurance Company	12833
INSURER B : NH Employers Insurance Company	13083
INSURER C : Federal Insurance Company	20281
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
U C C R C Inc.
C/O Tracy Judd
33 Christian Avenue
Concord, NH 03301

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 INSR	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: X POLICY; PRO-JECT; LOC; OTHER:	X	X	L1VD24296503	05/01/2020	05/01/2021	EACH OCCURRENCE	$1,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
							MED EXP (Any one person)	$5,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$3,000,000
							PRODUCTS - COMP/OP AGG	$3,000,000
								$
C	AUTOMOBILE LIABILITY; X ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; X HIRED AUTOS ONLY; X NON-OWNED AUTOS ONLY	X	X	73597778	05/01/2020	05/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
A	X UMBRELLA LIAB; X OCCUR; EXCESS LIAB; CLAIMS-MADE; DED; X RETENTION $0	X	X	L1VD24296603	05/01/2020	05/01/2021	EACH OCCURRENCE	$10,000,000
							AGGREGATE	$10,000,000
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		ECC60040002542020A 3A States: NH	05/01/2020	05/01/2021	X 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
A	Professional Liability			L1VD24296503	05/01/2020	05/01/2021	$1,000,000 Ea. Incident; $3,000,000 Aggregate	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Additional Insured by Contract, Agreement or Permit and Blanket Waiver of Subrogation is provided under the Commercial General Liability policy per Form 421-2429 03/16.

(See Attached Descriptions)

CERTIFICATE HOLDER
State of 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
[signature]

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State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and VILLA CREST HEALTHCARE CENTER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,970,400

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by: Lisa M. Morris
D938DBEB8CA54A0...
Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

VILLA CREST HEALTHCARE CENTER LLC

12/28/2020
Date

DocuSigned by: Karyn Miner
AA4073E6041D4A0...
Name: Karyn Miner
Title: Administrator

DocuSign Envelope ID: F6D4A494-BF46-4005-9F65-127FF89679C8

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 96,000.00, for the number of test listed in Section 4..
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 960 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment.#1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

Initials kM

Date 12/28/2020

DocuSign Envelope ID: F6D4A494-BF46-4005-9F65-127FF89679C8

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):
   - ☐ Surveillance
   - ☐ Outbreak/Response
   - ☐ County rate greater than 5%
   - ☐ County rate greater than 10%
5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
kM

Date

12/28/2020

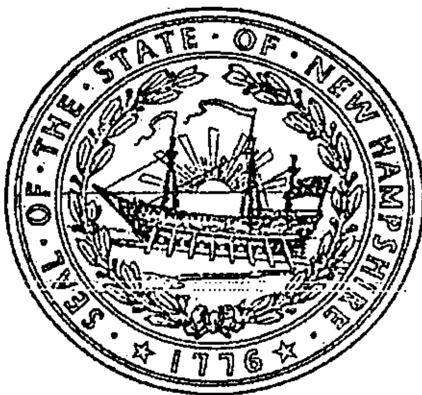
DocuSign Envelope ID: F6D4A494-BF46-4005-9F65-127FF89679C8

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 VILLA CREST HEALTHCARE CENTER, LLC is a New Hampshire Limited Liability Company registered to transact business in New Hampshire on May 20, 2011. 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; and the attached is a true copy of the list of documents on file in this office.

Business ID: 649997
Certificate Number: 0005038237



IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 4th day of November A.D. 2020.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Allison Purwin, 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 Villa Crest HealthCare Center LLC.
(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 Dec. 24, 2020, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Koryn Miner Administrator (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of Villa Crest HealthCare LLC, 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: 1/5/21

Signature of Elected Officer
Name: Allison E. Purwin
Title: Manager

DocuSign Envelope ID: F6D4A494-BF46-4005-9F65-127FF89679C8

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY) 12/23/2020

PRODUCER

USA Risk Group (Cayman LTD.) (877) 483-1850
P. O. Box 1085, Queensgate House, 5th Floor
Grand Cayman, KY1-1102
Cayman Islands

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: Premier Plus Insurance Company, LTD
INSURER B:
INSURER C:
INSURER D:
INSURER E:

INSURED

National HealthCare Corporation
100 E. Vine Street
Murfreesboro, TN 37130

COVERAGES This Certificate is not intended to specify all endorsements, coverages, terms, conditions and exclusions of the policies shown.

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	GENERAL LIABILITY ☑ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☑ OCCUR ☑ Professional Liability ☑ Premises Liability GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PROJECT ☐ LOC	PP 020	01/01/2021	01/01/2022	EACH OCCURRENCE	1,000,000.
					FIRE DAMAGE (Any one fire)	50,000.
					MED EXP (Any one person)	Excluded
					PERSONAL & ADV INJURY	Included
					GENERAL AGGREGATE	3,000,000.
					PRODUCTS - COMP/OP AGG	N/A
					NO Deductible Applie	
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON OWNED AUTOS ☐ $1000 Ded. Collision ☐ $250 Ded Comp				COMBINED SINGLE LIMIT (Ea accident)	
					BODILY INJURY (Per person)	
					BODILY INJURY (Per accident)	
					PROPERTY DAMAGE (Per accident)	
	GARAGE LIABILITY ☐ ANY AUTO ☐				AUTO ONLY - EACH ACCIDENT	
					OTHER THAN AUTO ONLY: EA ACC	
					AGG	
	EXCESS LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $ 0				EACH OCCURRENCE	
					AGGREGATE	
A	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY	10804014-16	01/01/2021	01/01/2022	☑ WC STATUTORY LIMITS ☐ OTHER	
					E.L. EACH ACCIDENT	1,000,000
					E.L. DISEASE-POLICY LIMIT	1,000,000
					E.L. DISEASE-EA EMPLOYEE	1,000,000
	OTHER					

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

Evidence of Insurance - Villa Crest HealthCare Center, LLC

CERTIFICATE HOLDER

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

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEROF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 30 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 COMPANY, ITS AGENTS OR REPRESENTATIVES

AUTHORIZED REPRESENTATIVE

Paul Macey

Certificate No

Holder Identifier :

State of New Hampshire
Department of Health and Human Services
Amendment #1

This Amendment to the Hospital-based Long Term Care Facility COVID-19 Testing Program contract is by and between the State of New Hampshire, Department of Health and Human Services ("State" or "Department") and VK DOVER LLC ("the Contractor").

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor on November 20, 2020 and presented to the Executive Council on TBD, the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 17, and Exhibit A, Revisions to Standard Contract Provisions, Paragraph 1.2., the Contract may be amended upon written agreement of the parties and appropriate State approval; and

WHEREAS, the parties agree to extend the term of the agreement, increase the price limitation, or modify the scope of services to support continued delivery of these services; and

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and conditions contained in the Contract and set forth herein, the parties hereto agree to amend as follows:

1. Modify COVID-19 Grant Agreement, Section 1., General Provisions: Identification., Subsection 1.8, to read:

   1.8 Grant Amount not to exceed: $1,968,300

2. Modify Grant Agreement Exhibit A-1, Scope of Services, Section 1.6, to read:

   1.6. The Contractor shall provide the pre-testing, testing and post-testing functions set forth above in accordance with routine testing guidance as defined in QSO-20-38-NH and as follows:

   1.6.1. The Contractor shall conduct Surveillance Testing in accordance with the following testing cycles and estimated test volumes based on the COVID-19 testing positivity rate in the county in which the Contractor operates:

   1.6.1.1. <5% County Positivity Rate = The Contractor shall test 100% of staff once per month and 10% of staff weekly. The 10% of selection of staff should be different each week.

   1.6.1.2. 5%-10% County Positivity Rate = The Contractor shall test 100% of staff once per week.

   1.6.1.3. >10% County Positivity Rate = The Contractor shall test 100% of staff twice per week.

   1.6.1.3.1. The Department shall reimburse the Contractor for a maximum of one (1) round of testing 100% of staff per week. The Contractor may conduct additional testing with Antigen POC or PCR through a contracted laboratory at the Contractor's expense.

   1.6.2. The Contractor may send Outbreak Testing for residents and staff to a contracted laboratory if increased volume is accepted at a reference laboratory.

   1.6.2.1. If Outbreak testing is needed for residents and the contracted reference laboratory is unable to bill an individual's insurance, the Department will be the payer last resort. The Contractor may submit a request for reimbursement for Outbreak Testing of residents to LTCFtesting@DHHS.nh.gov. The Department will approve such requests contingent upon funding availability.

3. Modify New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form by replacing it in its entirety with New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form Amendment #1, which is attached hereto and incorporated by reference herein.
4. Modify Grant Agreement Exhibit B, Methods and Conditions of Payment by replacing it in its entirety with Modify Grant Agreement Exhibit B, Methods and Conditions of Payment, Amendment #1, which is attached hereto and incorporated by reference herein.

All terms and conditions of the Contract and prior amendments not modified by this Amendment remain in full force and effect. This Amendment shall be retroactively effective to December 1, 2020, upon the Governor's approval issued under the Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, 2020-20, 2020-21, 2020-23, and any subsequent extensions.

IN WITNESS WHEREOF, the parties have set their hands as of the date written below,

State of New Hampshire
Department of Health and Human Services

DocuSigned by:
Lisa M. Morris
D938DBFB6CA54A0...

12/23/2020
Date

Name: Lisa M. Morris
Title: Director, Division of Public Health Srvcs.

VK DOVER LLC

DocuSigned by:
Tara Verge
7E7E8AAB39784A3...

12/23/2020
Date

Name: Tara Verge
Title: Administrator

GRANT AGREEMENT EXHIBIT B AMENDMENT 1

Methods and Conditions of Payment

1. Grantee shall register with the Department of Administrative Services for a State of New Hampshire vendor number (see page 1, para 1.6) in order for a payment to be issued. Payment will be issued by check or ACH, depending on the vendor registration.
2. The Department shall pay the Grantee a total amount of $ 93,900.00, for the number of test listed in Section 4.
3. The Grantee shall contract with a Clinical Laboratory Improvement Amendment Certified clinical laboratory, in accorance with Exhibit A-1 Scope of Services. The Department will pay for services from the date the subgrantee contract is awarded until the contract end date of December 30, 2020.
4. The Grantee shall bill for COVID-19 tests performed, during the period specified in Section 3, and will not exceed 939 test during the duration of the contract. A 10% plus or minus in staff is allowable.

Cost Per Test	$100

4.1. The Contractor shall only bill by the number of staff in each individual facility and not by the total number of staff in their combined facilities.

4.2. Funding for increased Surveillance Testing as specified in Grant Agreement Exhibit A-1, Scope of Services, Subparagraph 1.6.2., and Outbreak Testing is a shared price limitation of $1,874,400 across all vendors statewide.

4.3. The Grantee shall submit the Attachment A "New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking Form, Amendment #1" on the tenth (10) working day of the following month, in which staff testing as outlined in Exhibit A-1 Scope of Services begins, the Contractor shall:

4.3.1. Identifies and requests reimbursement for the number of Surveillance tests performed in the prior month.

4.3.2. Identifies and request reimbursement for the number of Outbreak tests performed in the prior month.

4.3.3. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.

5. The Grantee shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment.
6. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to LTCFtesting@DHHS.nh.gov.

DocuSign Envelope ID: 5444A0EE-5FDB-48D7-8DB7-FBF3447891B5

New Hampshire Long-Term Care Facility Sentinel Surveillance Tracking and Reimbursement Form

Please fill out form and return to: LTCFTesting@dhhs.nh.gov

1) Name of facility:
2) How many staff members does your facility have?
3) Staff testing lab utilized:
4) Reimbursement type (please check all that apply):

☐ Surveillance

☐ Outbreak/Response

☐ County rate greater than 5%

☐ County rate greater than 10%

5) How many residents does your facility have? (if outbreak/response is checked)
6) Resident testing lab utilized (if different from staff and outbreak/response is checked):

Month for reimbursement period: Select Month

Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	
Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				$100/Test	

Name

Title

DS
TV

Date

12/23/2020

One Click Certificate of Good Standing

Search Business | Business Information | Payment | Done

Business Details

Business Name:	VK DOVER, LLC	Business ID:	685455
Business Type:	Foreign Limited Liability Company	Business Status:	Good Standing
Business Creation Date:	01/18/2013	Name in State of Formation:	VK DOVER, LLC
Date of Formation in Jurisdiction:	01/18/2013		
Principal Office Address:	20 East Sunrise Highway, Valley Stream, NY, 11581, USA	Mailing Address:	20 East Sunrise Highway, Valley Stream, NY, 11581, USA
Citizenship / State of Formation:	Foreign/Delaware		
		Last Annual Report Year:	2020
		Next Report Year:	2021
Duration:	Perpetual		
Business Email:	tmueller@nathealthcare.com	Phone #:	516-705-4800
Notification Email:	tmueller@nathealthcare.com	Fiscal Year End Date:	NONE

Acknowledgment will be sent to the business email on record unless otherwise requested.

☐ I would like the acknowledgment to be sent to the following email address:

Email Address: [ ]

Note: Email address format is username@domain.net

Filing Fee:

Filing Fee: $5.00

Electronic Filing Fee: $2.00

Total Fees: $7.00

Back   Order Certificate of Good Standing

NH Department of State, 107 North Main St. Room 204, Concord, NH 03301 -- **Contact Us (/online/Home/ContactUS)**

Version 2.1 © 2014 PCC Technology Group, LLC, All Rights Reserved.

CERTIFICATE OF AUTHORITY

I, Marvin J. Ostreicher, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am the Managing Member of VK Dover, LLC dba Dover Center for Health and Rehabilitation ("Dover").

2. Tara Verge is duly authorized on behalf of Dover 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. 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:December 23, 2020

Signature
Name: Marvin J. Ostreicher
Title: Managing Member

Rev. 03/24/20

Client#: 1421981 NATIOHEA2

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/02/2020

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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
USI Insurance Services LLC
530 Preston Avenue
Meriden, CT 06450
855 874-0123

CONTACT NAME:
PHONE (A/C, No, Ext): 855 874-0123 FAX (A/C, No): 203 634-5701
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : MedPro RRG Risk Retention Group	13589
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dover Center for Health & Rehabilitaon
c/o National Health Care Associates, Inc
20 East Sunrise Hwy. 2nd Fl
Valley Stream, NY 11581

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY			NSC100602	01/01/2020	01/01/2021	EACH OCCURRENCE	$1,000,000
	X CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$50,000
							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 $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (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	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Supplemental Names
VK Augusta, LLC dba Augusta Center for Health and Rehabilitation
Brattleboro Crossings LLC dba Pine Heights at Brattleboro Center for Nursing and Rehabilitation
EP Brattleboro Realty Brattleboro Crossings, LLC
VK Yarmouth, LLC dba Brentwood Center for Health and Rehabilitation
(See Attached Descriptions)

CERTIFICATE HOLDER
State of NH
Department of Health and Human Services
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
[signature]

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DESCRIPTIONS (Continued from Page 1)

VK Brewer, LLC dba Brewer Center for Health and Rehabilitation
Bristol Crossings, LLC dba The Pines at Bristol Center for Health and Rehabilitation
Cambridge Health and Rehabilitation Center
VK Abington LLC Colony Center for Health and Rehabilitation
VK Newburyport LLC Country Center for Health and Rehabilitation
VK DOVER LLC Dover Center for Health and Rehabilitation
VK Bangor, LLC dba Eastside Center for Health and Rehabilitation
VK NATICK LLC ELIOT CENTER FOR HEALTH and Rehabilitation
EP Troy Crossings dba Pines at Heartwood Assisted Living Program
Glens Falls Crossings LLC dba Pines at Glens Falls Center for Health and Rehabilitation
EP GLENS FALLS REALTY LLC
VK Kennebunk, LLC dba Kennebunk Center for Health and Rehabilitation
Yom Tov Convalescent Inc dba Maywood Health
VK Wellesley LLC Newton Wellesley Ctr for Alzheimers Care
VK Norway, LLC dba Norway Center for Health and Rehabilitation
VK Marlborough LLC The Reservoir Center for Health and Rehabilitation
Rutland Crossings LLC DBA The Pines at Rutland Center for Nursing and Rehabilitation
EP Rutland Acquisition, LLC
VK East Bridgewater LLC Sachem Center for Health and Rehabilitation
New Milford Crossings, LLC Village Crest Center for Health and Rehabilitation
Westgate Center for Health and Rehabilitation
VK Bath, LLC dba Winship Green Center for Health and Rehabilitation

RE: Dover Center for Health & Rehabilitaon, 307 Plaza Drive, Dover, NH 03820.

Client#: 1196576 DOVERCEN

ACORD™

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INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : MEMIC Indemnity Co	11030
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dover Center for Health and
Rehabilitation; 20 East Sunrise Highway
Valley Stream, NY 11581

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	COMMERCIAL GENERAL LIABILITY; CLAIMS-MADE / OCCUR; GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC; OTHER:						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY; ANY AUTO; OWNED AUTOS ONLY; SCHEDULED AUTOS; HIRED AUTOS ONLY; 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	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		5101800620	07/01/2020	07/01/2021	X 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

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

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