

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		\$70,800		\$149,900		\$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	Current	\$36,800	Increased to Shared Price Limitation -	\$66,400	Revised	\$1,940,800
Bel-Air Nursing and Rehab Center, Inc.	257972	\$22,500	Total Shared Price Limitation	\$19,200		\$41,700	Total Shared Price Limitation -	\$1,916,100
Colonial Poplin Nursing Home, Inc.	234608	\$29,000	- \$0	\$33,600	\$1,874,400	\$62,600	\$1,874,400	\$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

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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

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

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	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.

His Excellency, Governor Christopher T. Sununu and the Honorable Council Page 5 of 5

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.

State of New Hampshire

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

Department of Health and Human Services

12/23/2020

Date

Decusioned by:
Name:
Name:
Title: Director, Division of Public Health Srvcs.

Greenbriar Operations, LLC.

12/23/2020

Date

Docusioned by:
Katina Greenhalph
Securical Processing Greenhalph
Name:
Name:
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 \$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.

Initials Katrina Greenhalgh

Date



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:			٠	
2) How man	y staff members does your facility	have?			
3) Staff testi	ng lab utilized:	i			
4) Reimburs	ement type (please check all that a	apply):			
So	urveillance				
	utbreak/Response				
c	ounty rate greater than 5%				
c	ounty rate greater than 10%				
5) How man	y residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident (esting lab utilized (if different fro	m staff and outbro	eak/response is checked) :	
	· ·				
Month for reimbu	rsement period: Select M	lonth			
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	
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vveek 1 rest Date	(if applicable)	(if applicable) Tested (if applicable)		Kate	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		

			\$100/Test		
	 			1 —	
Name	 ļ	Title		os Kg Date	
		THE STATE OF THE S	į	Kg	12/23/2020

State of New Hampshire **Department of State**

CERTIFICATE

1, 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

1. Ari Erlichman	, hereby certify that:
(Name of the elected Officer of the Corporat	on/LLC; cannot be contract signatory)
I am a duly elected Clerk/Secretary/Officer of(Co	reenbricar Operations, LLC. rporation/LLC Name)
2. The following is a true copy of a vote taken at a m held on December 2!, 20,20, at which a qu (Date)	eeting of the Board of Directors/shareholders, duly called and lorum of the Directors/shareholders were present and voting.
VOTED: That Hotring Greenhaleh 1 (Name and Title of Contract Signato	Administrator (may list more than one person)
is duly authorized on behalf of <u>CreeoViciar Design</u> (Name of Corporation	nonSunto enter into contracts or agreements with the State
of New Hampshire and any of its agencies or de documents, agreements and other instruments, and may in his/her judgment be desirable or necessary to	epartments and further is authorized to execute any and ald any amendments, revisions, or modifications thereto, which effect the purpose of this vote.
thirty (30) days from the date of this Certificate of A New Hampshire will rely on this certificate as evic position(s) indicated and that they have full authoric	ded or repealed and remains in full force and effect as of the this certificate is attached. This authority remains valid for uthority. I further certify that it is understood that the State of lence that the person(s) listed above currently occupy the ty to bind the corporation. To the extent that there are any he corporation in contracts with the State of New Hampshire, Signature of Elected Officer Name: ARI FRUHMAN
	Title: MECLER



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

CONTACT Andrew Gross
NAME:
PHONE
(AC. No. Ext): (718) 232-3300
[AC. No. Ext): (718) 232-3300
[AC. No. Ext): (718) 232-3300
[AC. No. Ext): (718) 256-9062
[ANDRESS: agross@fairmontins.com

INSURER(S) AFFORDING COVERAGE
NAIC **

Brooklyn			NY 11204	Matiana	Surer(S) AFFO	RDING COVERAGE		NAIC#	
INSURED			-	INSURER A ;					
Greenbriar Operations LLC	DBA Ca	مندادد		INSURER B ;					
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55 Harris Road		*	<u>j</u>	INSURER D :					
			ļ	INSURER E :					
Nashua			NH 03062	INSURER F :					
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OWNED SCHEDULED AUTOS ONLY						BODILY INJURY (Per accident)	\$		
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DESCRIPTION OF OPERATIONS / LOCATIONS / VEH	CLES (A	CORD 1	01, Additional Remarks Schedule, m	nay be attached if more s	pace is required)				
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	•			CANCELLATION					
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				THE EXPIRATION (DATE THEREOF	F, NOTICE WILL BE DELIVERI			
Proof of Insurance				ACCORDANCE WIT	TH THE POLICY	Y PROVISIONS.			
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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). CONTACT NAME: PRODUCER Rochelle Halperin THONE (718) 232-3300 E-MAIL Fairmont Ins. Brokers, Ltd. (718) 256-9062 FAX (A/C No): E-MAIL ADDRESS: rhalperin@fairmontins.com 1600 60th Street INSURER(S) AFFORDING COVERAGE NAIC # Brooklyn NY 11204 Atlantic Charter Insurance Company INSURER A : INSURED INSURER B : Greenbriar Operations LLC DBA Greenbriar Rehab and Healthcare INSURER C: 55 Harris Road INSURER D: INSURER E : Nashua NH 03062 INSURER F : CL20122305120 **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. ADDLISUBR POLICY EFF (MM/DD/YYYY) TYPE OF INSURANCE **POLICY NUMBER** LIMITS INSD WVD COMMERCIAL GENERAL LIABILITY DAMAGE TO RENTED CLAIMS-MADE OCCUR PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE POLICY LOC PRODUCTS - COMP/OP AGG OTHER: s AUTOMOBII E LIABILITY OMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) \$ OWNED SCHEDULED **BODILY INJURY (Per accident)** \$ AUTOS NON-OWNED AUTOS ONLY AUTOS ONLY HIRED AUTOS ONLY PROPERTY DAMAGE (Per accident) \$ S UMBRELLA LIAB OCCUR EACH OCCURRENCE **EXCESS LIAB** CLAIMS-MADE AGGREGATE DED RETENTION \$ WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) 1,000,000 E.L. EACH ACCIDENT Υ WCA00572300 11/01/2020 11/01/2021 N/A 1,000,000 E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below 1.000.000 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** 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. Proof of Insurance

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AUTHORIZED REPRESENTATIVE

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	Otea M. Morris
Date	Narae: DBL 68-28-4M Morris
	Title: Director, Division of Public Health Srvcs.
	BEAR MT HANOVER LLC
12/22/2020	Docusigned by: Martha Usley
Date	Neme: Messile IIsley
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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 \$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.



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

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

1 Test Date 2 Test Date 3 Test Date 4 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	Rate \$100/Test Rate \$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement Amount Reimbursement Amount Reimbursement Amount
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12/22/2020

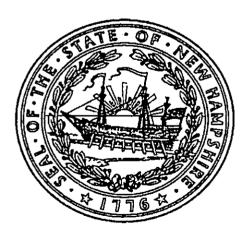
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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 Scal of the State of New Hampshire, this 27th day of October A.D. 2020.

William M. Gardner Secretary of State

CERTIFICATE OF AUTHORITY

1, 500 7 2,5kin	, 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	
2. The following is a true copy of a vote taken at a meeting of held on 0 c 10 bor 30 , 20 20 , at which a quorum of (Date)	the Board of Directors/shareholders, duly called and the Directors/shareholders were present and voting.
(Name and Title of Contract Signatory)	(may list more than one person)
is duly authorized on behalf of BM Hanous, LLC (Name of Corporation/ LLC)	to enter into contracts or agreements with the State
of New Hampshire and any of its agencies or department documents, agreements and other instruments, and any ammay in his/her judgment be desirable or necessary to effect the	landmants revisions or modifications the second
3. I hereby certify that said vote has not been amended or redate of the contract/contract amendment to which this certificate of thirty (30) days from the date of this Certificate of Authority. New Hampshire will rely on this certificate as evidence the position(s) indicated and that they have full authority to bind limits on the authority of any listed individual to bind the corporall such limitations are expressly stated herein.	further certify that it is understood that the State of the person(s) listed above currently occupy the
Dated: 12 22 20	
	Signature of Elected Officer
•	Name: Sam Ziskin
	Title: D

JACCHEAL

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 PRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

MPORTANT: 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).

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DESCRIPTIONS (Continued from Page 1)

JACC Management LLC & JACC Healthcare Center of Norwich LLC 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 264 Main Street, Reading, MA 01867

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

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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 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:
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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	Fire M. Morrie
Date	Namesobracianam. Morris
	Title: Director, Division of Public Health Srvcs.
	BEDFORD NURSING & REHABILIATION SERVICES LL
12/18/2020	Docusigned by: Neff Miller
Date	Name: 15 20 10 10 10 10 10 10 10 10 10 10 10 10 10
	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.
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- 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
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- 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.
- 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.



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 f	acility:				
2) How many	staff members does your facility	/ have?	•		
3) Staff testir	g lab utilized:		i P		
4) Reimburso	ment type (please check all that a	apply):			
☐ Su	rveillance				
o.	ntbreak/Response				
c	unty rate greater than 5%				
_	ounty rate greater than 10%	'		,	
_	residents does your facility have	O (if and branks	mana la shadadh		
6) Resident to	esting lab utilized (if different fro	m staff and outbro	eak/response is checked):	
					
th for reimbu	rsement period: Select M	lonth			
	Week 1 Second Test Date	Total Staff	Residents Tested	1	0.1.1
ek 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	Reimbursement Amount
				\$100/Test	
ek 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
_,				\$100/Test	
ek 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
· ·				\$100/Test	
ek 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
				\$100/Test	
ek 5 Test Date applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
	(**************************************	, asta	(ii opplicable)	\$100/Test	Amount
				<u> </u>	<u> </u>
2		Title		 /-	os L Date

12/18/2020



Business Information

Business Details

Business Name: SERVICES, LLC **BEDFORD NURSING & REHAB**

Domestic Limited Liability

Business Type: Company

Management Style: Manager Managed

Business Creation Date: 07/01/2014

Date of Formation in 07/01/2014

Principal Office Address: 480 Donald Street, Bedford, NH,

03110, USA

Citizenship / State of Domestic/New Hampshire

Last Annual 2020 Report Year:

Business ID: 710969

Business Status: Good Standing

Name in State of Not Available

Formation:

Mailing Address: NONE

Next Report Year: 2021

Duration: Perpetual

Business Email: john.turcotte@BNRCenter.com

Phone #: 603-622-4323

Fiscal Year End NONE

Date:

Notification Email: NONE

Principal Purpose

S.No **NAICS Code NAICS Subcode**

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 480 Donald Street, Bedford, NH, 03110, USA

Address:

Registered Mailing

480 Donald Street, Bedford, NH, 03110, USA

Address:

Trade Name Information

Business Name

Business ID

Business Status

BNRC

(/online/BusinessInquire/TradeNameInformation? 711053

businessID=532693)

Bedford Nursing & Rehabilitation Center

Vonline/BusinessInquire/TradeNameInformation? 711048

businessID=536958)

Active

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

(Name of the elected	ーとのでを I Officer of the Corporation/LLG	, hereby certic; cannot be contract signatory)	fy that:
1. I am a duly elected Clerk/S	Secretary/Officer of Bello (Corporati	on/LLC Name)	Services, LLC
2. The following is a true copheld on Perm by 22	y of a vote taken at a meeting -, 20 <u>20</u> , at which a quorum ((Date)	of the Board of Directors/sharehof the Directors/shareholders we	nolders, duly called and ere present and voting.
VOTED: That Zeit-res	Mi((er a Th	u Turcore (may list m	ore than one person)
is duly authorized on behalf o	(Name of Corporation/ LLC	Lesto enter into contracts or ag	reements with the State
documents, agreements and	y of its agencies or departments, and any lesirable or necessary to effect	ents and further is authorized amendments, revisions, or modute purpose of this vote.	to execute any and al difications thereto, which
date of the contract/contract thirty (30) days from the dat New Hampshire will rely on position(s) indicated and that	amendment to which this ce e of this Certificate of Authorit this certificate as evidence they have full authority to b listed individual to bind the cor	repealed and remains in full for rtificate is attached. This authory. I further certify that it is under that the person(s) listed above ind the corporation. To the extraction in contracts with the States.	rity remains valid for rstood that the State of currently occupy the rent that there are any
Баюи. <u> 1 - 1 - 2 - 2 - 2 - 2</u>		Signature of Elected Office Name: John M. Turne Fille: Sole Mamber	ore.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DOYYYY)

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(los) 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). CONTACT NAME: Teri Davis CGI Business Insurance (886) 841-4600 (886) 574-2443 (A/C. No): (A/C. No. Ext): 5 Dartmouth Drive TDavis@CGf8usinessinsurance.com ADDRESS: INSURER(S) AFFORDING COVERAGE Auburn NH 03032 CNA INSURER A : INSURED National Casualty Company INSURER B: Bedford Nursing & Rehab Services LLC INSURER C : DBA: Bedford Nursing & Rehabilitation Center INSURER D: 480 Donald St INSURER E : Bedford NH 03110 INSURER F : 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, ADOLSUBA INSD WYD POLICY EFF POLICY EXP
(MM/DD/YYYY) (MM/DD/YYYY) TR TYPE OF INSURANCE POLICY NUMBER LIMITS COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE DAVAGE TO RENTED PREMISES (Ea occurrence) CLAIMS-MADE 100,000 10.000 MED EXP (Any one person) \$ 602792490 10/01/2020 10/01/2021 1,000,000 PERSONAL & ADV INJURY ŝ GEN'L AGGREGATE LIMIT APPLIES PER: 3,000,000 GENERAL AGGREGATE POLICY 1,000,000 PRODUCTS - COMP/OP AGG OTHER: **Employee Benefits** s 1.000.000 AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT (Es accident) ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY MIREU AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) UNIBRELLA LIAB OCCUR 5.000,000 EACH OCCURRENCE EXCESS LIAD UMB80727250 10/01/2020 10/01/2021 CLAIMS-MADE 5,000,000 AGGREGATE RETENTION # 0E0 WORKERS COMPENSATION PER STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE II yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT D&O Per Claim \$2,000,000 D&O Liability & EPL В EKO3347628 10/10/2019 10/10/2020 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 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN Visiting Nurse Association of Manchester & Southern NH ACCORDANCE WITH THE POLICY PROVISIONS. 1070 Holt Ave, Ste 1400 AUTHORIZED REPRESENTATIVE Manchester NH 03109



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

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
Excess Insurance Midwest Employers Casualty Corp	EWC009477	2/1/2020 12:00 AM	2/1/2021 12:00 AM	Workers' Compensation Statutory Employer's Liability \$1,000,000

Description of Operations:

■ Excluded Officer

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.

Iohn 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.

12/01/2020

Authorized Representative

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 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.</p>
 - 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.

State of New Hampshire

Department of Health and Human Services

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

Date

Docusigned by:

Name.

Title: Director, Division of Public Health Srvcs.

BEL-AIR NURSING AND REHAB CENTER INC

12/23/2020

Date

Name.

Docusigned by:

Robert Lucy

Name.

Name.

Docusigned by:

Robert Lucy

Name.

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 \$ 42,100.00, for the number of test listed in Section 4.
- 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.

Data 12/23/202

1) Name of facility:



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

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

3) Staff testin	ng lab utilized:		1			
4) Reimburs	ement type (please check all that a	innly):				
	·	,				
∟ Su	erveillance					
O	utbreak/Response					
☐ c	ounty rate greater than 5%					
	ounty rate greater than 10%					
<u></u> С	ounty rate greater than 1076					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident t	esting lab utilized (if different fro	m staff and outbr	eak/response is checked):		
Month for reimbu	rsement period: Select M	lonth				
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	(if applicable)	Tested	(if applicable)	\$100/Test Rate	Amount	
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Business Information

Business Details

Business Name: CENTER, INC. BEL-AIR NURSING AND REHAB

Business ID: 696435

Business Type: Domestic Profit Corporation

Business Status: Good Standing

Business Creation Date: 08/20/2013

Name in State of Not Available Incorporation:

Date of Formation in 08/20/2013

Jurisdiction:

Principal Office Address: 560 Granite Lake Rd, Munsonville,

NH, 03457, USA

Mailing Address: NONE

Citizenship / State of Incorporation: Domestic/New Hampshire

Last Annual Report 2020

Next Report Year: 2021

Duration: Perpetual

Business Email: s.ellison@CLRM.com

Phone #: 603-621-7100

Notification Email: NONE

Fiscal Year End NONE

Date:

Principal Purpose

S.No **NAICS Code**

NAICS Subcode

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

dress
ake Road, Munsonville, NH, 03457, USA
ake Road, Munsonville, NH, 03457, USA
ake Road, Munsonville, NH, 03457, USA
ake Road, Munsonville, NH, 03457, USA
l

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



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(les) must be endorsed. If SUBROGATION IS WAIVED, subject to

t	he terms and conditions of the policy, ertificate holder in lieu of such endors	certa emer	in po it(s).	licies may require an endo	orseme	nt. A stateme	ent on this co	ertificate does not confer r	ights !	to the
PRO	DUCER			· · · · · · · · · · · · · · · · · · ·	CONTACT Susan Gilman					
TH	E ROWLEY AGENCY INC.				PHONE (A/C, No. Ext): (603) 224-2562 FAX (A/C, No): (603) 224-8012					-8012
45	Constitution Avenue				E-MAIL ADDRE	SS: Sgilman	@rowleyage	ncy.com		
Ρ.	D. Box 511							IDING COVERAGE		NAIC #
Co	ncord NH 03	302-	0511	i	INSURE	RA: Submiss				NAIC#
INS	JRED							of Reading PA	$\neg \neg$	20427
Be.	Bel-Air Nursing and Rehab Center, Inc.				RC:Columbi					
29 Center Street				1	RD:Granite					
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	ALL OWNED SCHEDULED AUTOS	1	İ					BODILY INJURY (Per accident) \$;	
	X HIRED AUTOS X NON-OWNED AUTOS							PROPERTY DAMAGE (Per accident)	;	
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	(Mandatory in NH)							E.L. DISEASE - EA EMPLOYEE \$,	1,000,000
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FOR INFORMATIONAL PURPOSES ONLY				SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.					BEFORE	
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	1				Susan Gilman/SJG Susan Simen					

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.

12/18/2020

12/17/2020

Date

Date

- 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.

State of New Hampshire

Varne 1176 Lbag Queiros

admn

Title:

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

Department of Health and Human Services

Docusigned by:

Namewood by:

Namewood by:

Title: Director, Division of Public Health Srvcs.

COLONIAL POPLIN NURSING HOME INC

Docusigned by:

Give Awirds

COLONIAL POPLIN NURSING HOME INC SS-2021-DPHS-11-LONGT-21-A01

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

- 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.
- 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.

12/17/2020 Date _____: 1) Name of facility:



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

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

				•		
2) How many	y staff members does your facility	y have?	,			
3) Staff testin	ng lab utilized:				•	
4) Reimburse	ement type (please check all that	apply):				
Su	rveillance					
Ou	utbreak/Response					
Co	ounty rate greater than 5%					
c _c	ounty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)		,	
6) Resident to	esting lab utilized (if different fro	m staff and outbr	eak/response is checked):		
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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 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

(Name of the elected Officer of the Corporation/L	, hereby certify that: LC; cannot be contract signatory)
1. I am a duly elected Clerk/Secretary/Officer of Corpora	ation/LLC Name)
2. The following is a true copy of a vote taken at a meeting held on, 20, 20, at which a quorum (Date)	g of the Board of Directors/shareholders, duly called and n of the Directors/shareholders were present and voting.
VOTED: That Give Queivos (Name and Title of Contract Signatory)	(may list more than one person)
is duly authorized on behalf of Colon's / Verylin North	c //www.to enter into contracts or agreements with the State
of New Hampshire and any of its agencies or departs documents, agreements and other instruments, and any may in his/her judgment be desirable or necessary to effe	ments and further is authorized to execute any and all y amendments, revisions, or modifications thereto, which ect the purpose of this vote.
3. I hereby certify that said vote has not been amended of date of the contract/contract amendment to which this of thirty (30) days from the date of this Certificate of Author New Hampshire will rely on this certificate as evidence position(s) indicated and that they have full authority to limits on the authority of any listed individual to bind the coall such limitations are expressly stated herein.	certificate is attached. This authority remains valid for rity. I further certify that it is understood that the State of e that the person(s) listed above currently occupy the bind the corporation. To the extent that there are any
Dated:/2/2//Z/)	1411661
· ·	Signature of Elected Officer, Name: Jest Phillynelle
	Title: President

COLOPOP-01

ACORD

CERTIFICATE OF LIABILITY INSURANCE

LJUKIC

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). CONTACT Anna Gallant, ACSR, CISR, CRIS People's United Insurance Agency, Inc. PHONE (A/C, No, Ext): (603) 427-7534 413 FAX (A/C, No):(844) 254-7670 1555 Lafayette Road FORESS: Anna.Gallant@peoples.com Portsmouth, NH 03801 INSURER(S) AFFORDING COVERAGE NAIC # INSURER A : Columbia Casualty Company 31127 INSURED 13083 INSURER B: New Hampshire Employers Insurance Colonial Poplin Nursing Home, Inc. INSURER C : Poplin Way, Inc & Bittersweet Prop, LLC INSURER D 442 Main Street Fremont, NH 03044 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. ADDL SUBR POLICY EFF POLICY EXP TYPE OF INSURANCE **POLICY NUMBER** X COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE
DAMAGE TO RENTED
PREMISES (Ea occurrence) X CLAIMS-MADE 100,000 LOCCUR 6049803248 7/1/2020 7/1/2021 5,000 MED EXP (Any one person) 1,000,000 PERSONAL & ADV INJURY 3,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE JECT POLICY LOC PRODUCTS - COMP/OP AGG OTHER: COMBINED SINGLE LIMIT (Ea accident) **AUTOMOBILE LIABILITY** ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS BODILY INJURY (Per accident)
PROPERTY DAMAGE
(Per accident) HIRED ONLY NON-SYNED UMBRELLA LIAB OCCUR **EACH OCCURRENCE** EXCESS LIAB CLAIMS-MADE **AGGREGATE** DED RETENTIONS B WORKERS COMPENSATION AND EMPLOYERS' LIABILITY X | PER STATUTE ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) ECC60040003442019A 1/22/2020 1/22/2021 100,000 E.L. EACH ACCIDENT Υ N/A 100,000 E.L. DISEASE - EA EMPLOYEE \$ yes, describe under DESCRIPTION OF OPERATIONS below 500,000 E.L. DISEASE - POLICY LIMIT 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 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. New Hampshire Department of Health and Human Services 129 Pleasant St Concord, NH 03301 AUTHORIZED REPRESENTATIVE People's United Insurance Agency, Inc.

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 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.

Date -

Date

- 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.

State of New Hampshire

Department of Health and Human Services

County Administrator

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.

1/14/2021 View M. Morris Nameseesseum. Morris Title: Director, Division of Public Health Srvcs. COUNTY OF BELKNAP DocuSigned by: 1/14/2021 Delra Shackett Name:

Title:

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 \$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.

1) Name of facility:



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

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

3) Have many	u un ff manch and de a come for itie				
2) How many	y staff members does your facility	/ nave /			
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lame		Title			DS Date

CERTIFICATE OF AUTHORITY

- I, David DeVoy, hereby certify that:

 (Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)
- 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 Office

Name: David DeVoy

Title: Commissioner, Chairman



Department of Health and Human Services

129 Pleasant Street

Concord, NH 03301

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:		Compan	ny Affording Coverage:	
Belknap County 34 County Drive Laconia, NH 03246	607		Bow B 46 Doi	ublic Risk Management Ex Irook Place novan Street Ird, NH 03301-2624	change - Primex ³
Type of Coverage	Effective Date (mm/dd/yyyy)	Expiration L (mm/dd/yy		Limits - NH Statutory Limits	May Apply, If Not:
X General Liability (Occurrence Form) Professional Liability (describe) Claims Made Occurre	1/1/2020 1/1/2021	1/1/202 1/1/202	1 _	Each Occurrence General Aggregate Fire Damage (Any one fire) Med Exp (Any one person)	\$ 5,000,000 \$ 5,000,000
Automobile Liability Deductible Comp and Coll: \$1,000 Any auto	1/1/2020 1/1/2021	1/1/202 1/1/202	2	Combined Single Limit (Each Accident) Aggregate	\$ 5,000,000 \$ 5,000,000
X Workers' Compensation & Employer	- 17172020	1/1/202	' ⊨	X Statutory Each Accident	\$ 2,000,000
	1/1/2021	1/1/202	-	Disease — Each Employee Disease — Policy Limit	\$ 2,000,000
X Property (Special Risk includes Fire and	Theft) 1/1/2020 1/1/2021	1/1/202 1/1/202		Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: \$1,000
Description: Proof of Primex Member cover	age only.				
CERTIFICATE HOLDED	15.	_		1	
CERTIFICATE HOLDER: Additional C	overed Party Loss	Payee	Primex By: Date:	3 – NH Public Risk Manage **Many Eak Purcett** 12/16/2020 mpurcell@nl	-
Cidio di 1464 Hallipallile			July.	TOTE OF THE OFFICE HISTORIA	ipinitox.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.

COUNTY OF CARROLL SS-2021-DPHS-11-LONGT-33-A01

- 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

Date

Name: HOWAND CHAMIDE



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
L	

- 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.

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:

27 How man	ly starr members does your facilit	y nave?	3			
3) Staff testi	ng lab utilized:	···	j -		,	
4) Reimburs	ement type (please check all that	nanh()				
·	ement type (please check all that	арргу).				
s	urveillance					
·	utbreak/Response					
Пс	ounty rate greater than 5%					
☐ C:	ounty rate greater than 10%					
5) How many	y residents does your facility have	e? (if outbreak/re	sponse is checked)	•		
6) Resident (esting lab utilized (if different fro	m staff and outbr	 cak/response is checked	h:		
]			
					•	
onth for reimbu	rsement period: Select M	lonth		4		
Veek 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement	
		resteu	(п аррисавле)	\$100/Test	Amount	
/eek 2 Test Date	Week 2 Second Test Date	Total Staff	Residents Tested		Reimbursement	
	(if applicable)	Tested	(if applicable)	Rate	Amount	
	W			\$100/Test		
Veek 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
				\$100/Test		
eek 4 Test Date	Week 4 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	
	(if applicable)	Tested	(if applicable)		Amount	
eek 5 Test Date	Week 5 Second Test Date	Total Staff	Residents Tested	\$100/Test	Poi-phusses	
(if applicable)	(if applicable)	Tested	(if applicable)	Rate	Reimbursement Amount	
				\$100/Test		
				·	···	
				}	<u> </u>	
ne		Title		,-	Date	

CERTIFICATE OF AUTHORITY

We, 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: 01/13/202/

Signature of Elected Officer

Name: Terry No Canth

itle: CHRIC BOARD

Commissioner Kimberly Tessari

> Commissioner Matthew Placke



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 torth 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 Legaf Liability Ctaims-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 after the coverage afforded by the coverage categories listed below.

Participating Member:	Member Number:		Compai	ny Affording Coverage:		
Carroll County 95 Water Village Road Ossipee, NH 03864	600		NH Public Risk Management Exchange - Prime Bow Brook Place 46 Donovan Street Concord, NH 03301-2624			
Type of Coverage	(Effective Date:	Expiration (mm/dd/y)	Date :	Limits - NH Statutory Limits	May Apply, If Not:	
X General Liability (Occurrence Form) Professional Liability (describe) Claims Made Occurrence	1/1/2020 1/1/2021	1/1/202 1/1/202	21	Each Occurrence General Aggregate Fire Damage (Any one fire) Med Exp (Any one person)	\$ 5,000,000	
Automobile Liability Deductible Comp and Coll: \$1,000 Any auto	1/1/2020 1/1/2021	1/1/202 1/1/202	22	Combined Single Limit (Each Accident) Aggregate	\$ 5,000,000 \$ 5,000,000	
X Workers' Compensation & Employers' Liabili	1/1/2020 1/1/2021	1/1/202 1/1/202	2	X Statutory Each Accident Disease — Each Employee Disease — Policy Limit	\$ 2,000,000	
X Property (Special Risk includes Fire and Theft)	1/1/2020 1/1/2021	1/1/202 1/1/202		Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: \$1,000	
Description: Proof of Primex Member coverage only.						
CERTIFICATE HOLDER: Additional Covered P	arty Loss P		Primex ³ By:	– NH Public Risk Manage	ment Exchange	
State of New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301			Date:	12/8/2020 mpurcell@nhr Please direct inquire Primex³ Claims/Coverage 603-225-2841 pho 603-228-3833 fa	es to: e Services one	

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.

- 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 UBI BEENEN MOPPIS

Director, Division of Public Health Srvcs.

COUNTRY OF CHESHIRE

DocuSigned by: kathryn kindopp

Name Kathaya Kindopp

Title: Administrator

12/18/2020

Date

Date

12/18/2020

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.
- 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
	<u></u>

- 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.



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

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

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			\ \	KK		12/18/20)20

\$100/Test



CERTIFICATE OF AUTHORITY

I,Robert England	, hereby certify that:
(Name of the elected Officer of the Co	orporation/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 held on December 30, 2020, at which a quort (Date)	at a meeting of the Board of Directors/shareholders, duly called and im of the Directors/shareholders were present and voting.
VOTED: That Kathryn Kindopp, Cheshire Co- (Name and Title of Contract	unty Maplewood Nursing Home Administrator Signatory)
is duly authorized on behalf of Cheshire Cour (Name of Co	nty to enter Into contracts or agreements with the State orporation/ LLC)
of New Hampshire and any of its agencie documents, agreements and other instrume may in his/her judgment be desirable or nece	es or departments and further is authorized to execute any and a ents, and any amendments, revisions, or modifications thereto, which assary to effect the purpose of this vote.
date of the contract/contract amendment to thirty (30) days from the date of this Certific New Hampshire will rely on this certificate position(s) Indicated and that they have full	Kobert English
	Signature of Elected Officer Name: Robert Englund Title: Clerk of the Board of Commissioners



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 bohalf 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 Primox³. 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 after the coverage afforded by the coverage categories listed below.

Participating Member:	Mem	iber Number:		Compar	ny Affording Coverage:	
Cheshire County 12 Court Street 1st Floor - Room 171 Keene, NH 03431	601			Bow B 46 Do Conco	iblic Risk Management Ex trook Place novan Streot ord, NH 03301-2624	
Type of Coverage		Effective Date	Expiration (mm/dd/)	Dala	Limits NH Statutory Limits	May Apply, If Not
X General Liability (Occurrence Professional Liability (descr	Form)	1/1/2020	1/1/202	21	Each Occurrence General Aggregate Fire Damage (Any one fire) Med Exp (Any one person)	\$ 5,000,000 \$ 5,000,000
Automobile Llability Deductible Comp and Coll: Any auto					Combined Single Limit (Each Accident) Aggregate	
X Workers' Compensation & E	mployers' Liability	1/1/2020	1/1/202	-	X Statutory Each Accident Disease — Each Employee Disease — Policy Limit	\$2,000,000 \$2,000,000
Property (Special Risk include	s Fire and Thoft)				Blanket Limit, Replacement Cost (unless otherwise stated)	
Description: Proof of Primex Memb	per coverage only.	-,-		,		
CERTIFICATE HOLDER: Ac	Iditional Covered Party	Loss P		Drimay	3 – NH Public Risk Manage	
	CONTROL COVERED PARTY	2035 P	ayee	Ву:	Mary Beld Purcell	ment exchange
State of New Hampshire Department of Health and Human S 129 Pleasant Street Concord, NH 03301	ervices			Date:	10/21/2020 mpurcell@r Ploase direct inquire Primex³ Claims/Coverag 603-225-2841 phc 603-228-3833 fa	e Services one

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 opérates:
 - 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.</p>
 - 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.

State of New Hampshire

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

Department of Health and Human Services

12/23/2020

Date

Docusioned by:
Name:
Name:
Name:
Director, Division of Public Health Srvcs.

COUNTY OF COOS

12/23/2020

Date

Name:
Docusioned by:
Lyun M. Bull
Name:
Name:
Title: NHA

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.



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 f	acility:		1		
2) How many	y staff members does your facility	y have?	,		
3) Staff testin	ng lab utilized:				
			}		
4) Reimburse	ement type (please check all that	apply);			
Su Su	rveillance			·	
☐ 0i	utbreak/Response				
_					
<u> </u>	ounty rate greater than 5%				
Cc	ounty rate greater than 10%				
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident to	esting lab utilized (if different fro	m staff and outbr	eak/response is checked):	
			p	•	
th for reimbu	rsement period: Select M	lonth			
ek 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
			(***)	\$100/Test	Amount
k 2 Test Date	Week 2 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement
	(if applicable)	Tested	(if applicable)	· F	Amount
	Week 3 Second Test Date	Total Staff	Residents Tested	\$100/Test	- Rainshura and
k 3 Test Date	(if applicable)	Tested	(if applicable)	Rate	Reimbursement Amount
·				\$100/Test	
k 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
			(iii approacte)	\$100/Test	Amount
k 5 Test Date	Week 5 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement
applicable)	(if applicable)	Tested	(if applicable)		Amount
				\$100/Test	
			<u>.</u>		
	1				
					-DS



Coös County Commissioners' Office

P.O. Box 10 West Stewartstown, N.H. 03597 603-246-3321 fax: 603-246-8117

CERTIFICATE OF AUTHORITY

- I, <u>Rick Samson, Clerk of New Hampshire Coös County Board of Commissioners</u>, 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 <u>Coös County</u>, <u>Nursing Home</u> 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 (Dec 29, 2020 10:35 EST)

Signature of Elected Officer Name:

Title:

COMMISSIONERS

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



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:			
PO	s County Box 10 st Stewartstown, NH 03597	602		Bow 46 D	Public Risk Management Ex Brook Place Jonovan Street cord, NH 03301-2624	change - Primex ³	
	Type of Coverage	" Effective Date (mm/dd/yyyy)	Expiration (mm/dd/y		Limits - NH Statutory Limits	May Apply, If Not;	
Х	General Liability (Occurrence Form)	7/1/2020	7/1/202		Each Occurrence	\$ 5,000,000	
Х	Professional Liability (describe)				General Aggregate	\$ 5,000,000	
	Claims Occurrence				Fire Damage (Any one fire)		
					Med Exp (Any one person)	<u> </u>	
X	Automobile Liability Deductible Comp and Coll: \$1,000	7/1/2020	7/1/202	21	Combined Single Limit (Each Accident)	\$5,000,000	
	Any auto				Aggregate	\$5,000,000	
X	Workers' Compensation & Employers' Liabil	ity 1/1/2020	1/1/202	21	X Statutory		
					Each Accident	\$2,000,000	
					Disease — Each Employee	\$2,000,000	
	<u> </u>				Disease - Policy Limit		
Х	Property (Special Risk includes Fire and Theft)	7/1/2020	7/1/20	21	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: \$1,000	
Des	cription: Proof of Primex Member coverage only						
CER	TIFICATE HOLDER: Additional Covered F	Party Loss P	avee	Prime	ex ³ – NH Public Risk Manage	ment Exchange	
				By:	Mary Beth Purcell		
_	_	<u>. </u>		•	•		
	s County Box 10			Date:			
	t Stewartstown, NH 03597				Please direct inquire Primex ³ Claims/Coverag 603-225-2841 pho 603-228-3833 fa	e Services one	

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.

- 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	Tien M. Morris
Date	Name:
	Title: Director, Division of Public Health Srvcs.
	COUNTY OF COOS
	DocuSigned by:
12/18/2020	Laura Mills
Date	Name:
	Tile. 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.
- 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.
- 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 <a href="https://lieu.org



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

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

2) How many	staff members does your facility	have?			
3) Staff testin	g lab utilized:				
4) Reimburse	ment type (please check all that a	apply):			
Su	rveillance				
☐ Ou	tbreak/Response				•
	unty rate greater than 5%				
_	unty rate greater than 10%	•			
_		0 (15	and the state of t		
	residents does your facility have				
Resident to	esting lab utilized (if different from	m staff and outbre	eak/response is checked):	
		,			·
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	,		
nth for reimbu	rsement period: Select M	lonth			
nth for reimbu	rsement period: Select M	lonth			
	Week 1 Second Test Date	Total Staff	Residents Tested (if applicable)	Rate	Reimbursement Amount
			Residents Tested (if applicable)	Rate \$100/Test	Reimbursement Amount
ek 1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date	Total Staff Tested Total Staff	(if applicable) Residents Tested		Amount Reimbursement
nth for reimburek 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	(if applicable)	\$100/Test	Amount
eek 1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date	Total Staff Tested Total Staff Tested Total Staff	(if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test	Reimbursement Amount Reimbursement
eek 1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test	Amount Reimbursement Amount
eek 1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement
eek 1 Test Date eek 2 Test Date eek 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement Amount
eek 1 Test Date eek 2 Test Date eek 3 Test Date eek 4 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable) Week 5 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement Amount Reimbursement Amount
ek 1 Test Date ek 2 Test Date ek 3 Test Date ek 4 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement Amount Reimbursement Amount

12/18/2020



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:		Men	Member Number:			Company Affording Coverage:			
Coos County PO Box 10 West Stewartstown, NH 03597			602		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 (mm/dd/y		Limits - NH Statutory Limits	May Apply, If Not:		
X	General Liability (Oct		7/1/2020	7/1/20	21	Each Occurrence	\$ 5,000,000		
	Professional Liability Claims	' <u> </u> '				General Aggregate	\$ 5,000,000		
	Made Made	Occurrence				Fire Damage (Any one fire)			
						Med Exp (Any one person)			
X	Automobile Liability Deductible Comp a	and Coll: \$1,000	7/1/2020	7/1/20	21	Combined Single Limit (Each Accident)	\$5,000,000		
	Any auto					Aggregate	\$5,000,000		
Х	Workers' Compensa	tion & Employers' Liability	1/1/2020	1/1/20:	21	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		
Des	cription: Proof of Prime	ex Member coverage only.		·					
CER	TIFICATE HOLDER:	Additional Covered Party	Loss P	ayee	Prime	ex ³ – NH Public Risk Manage	ment Exchange		
-	<u></u>		—4—· <u>-</u> - <u>-</u>	- 	By:	Mary Beth Purcell			
DUL	IC Chata of NIU	· .				•	. i		
	IS, State of NH Pleasant Street				Date:	11/6/2020 mpurcell@nh Please direct inquire			
	cord NH 03301			:		Primex ³ Claims/Coverage 603-225-2841 pho	e Services ene		



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	harahu andifi i ihati
(Name of the elected Officer of the Corporation/LLC; cannot be	, hereby certify that:
1. I am a duly elected Clerk/Secretary/Officer of COOS COUNTY	•
(Corporation/LLC Nam	ne)
2. The following is a true copy of a vote taken at a meeting of the Board held on October 13, 2020, at which a quorum of the Directors/sharehold (Date)	of Directors/shareholders, duly called and ders were present and voting.
VOTED: That Laura Mills, Nursing Home Administrator of Coos Coo Hospital (Name and Title of Contract Signatory)	unty Institution DBA Coos County Nursing than one person)
is duly authorized on behalf of <u>COOS COUNTY</u> to enter in (Name of Corporation/ LLC)	into contracts or agreements with the State
of New Hampshire and any of its agencies or departments and fu documents, agreements and other instruments, and any amendment may in his/her judgment be desirable or necessary to effect the purpose	s, revisions, or modifications thereto, which
3. I hereby certify that said vote has not been amended or repealed an date of the contract/contract amendment to which this certificate is a thirty (30) days from the date of this Certificate of Authority. I further on New Hampshire will rely on this certificate as evidence that the per position(s) indicated and that they have full authority to bind the corplimits on the authority of any listed individual to bind the corporation in call such limitations are expressly stated herein.	ttached. This authority remains valid for ertify that it is understood that the State of son(s) listed above currently occupy the poration. To the extent that there are any
Dated; 0xc 29, 2020	<u> </u>
Signat	ure of Elected Officer
	Rick Samson
Title: C	Coos County, Clerk
•	
·	

COMMISSIONERS

Rev. 03/24/20 THOMAS M. BRADY, Jefferson • PAUL R. GRENIER, Berlin • RICK SAMSON, Stewartstown

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.</p>
 - 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	Docusigned by: Jish M. Morris
Date	Name: Morris
•	Title: Director, Division of Public Health Srvcs.
	COUNTRY OF GRAFTON
12/21/2020	Cong & Jahore
Date	Name Effato Labore

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 \$160,000.00, for the number of test listed in Section 4.
- 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.

Date 12/21/2020



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

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

7 (facility:		1		
2) How man	y staff members does your facility	y have?			
3) Staff testi	ng lab utilized:				
4) Reimburs	ement type (please check all that	apply):			
□ s	urveillance				
_	utbreak/Response				
	·				
_	ounty rate greater than 5%	•			
<u></u>	ounty rate greater than 10%				
5) How man	y residents does your facility have	? (if outbreak/res	sponse is checked)		
6) Resident t	esting lab utilized (if different fro	m staff and outbr	 eak/response is checked 	1):	
L	_ 	_			
nth for reimbu	rsement period: Select M	lopth			
nth for reimbu	rsement period: Select M	lonth			
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eek 1 Test Date eek 2 Test Date eek 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement Amount

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 <u>December 22, 2020</u>:

VOTED: That <u>Craig J. Labore</u>, <u>Grafton County Nursing Home Administrator</u> is duly authorized on behalf of <u>Grafton County</u> 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.

MMour)

(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.

My Commission Expires July 11, 2023

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 after the coverage afforded by the coverage categories listed below.

alle	r the coverage allorded by the coverage categories listed be	NOW.						
Participating Member: Member Num				Company Affording Coverage:				
385 Box	5 Dartmouth College Highway	603			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 (mm/dd/y		Limi	ts - NH Statutory Limits	May Apply, If Not:	
Х	General Liability (Occurrence Form)	7/1/2020	7/1/20		Eac	h Occurrence	\$ 5,000,000	
	Professional Liability (describe)			- '	Gen	eral Aggregate	\$ 5,000,000	
	Claims Occurrence				Fire fire)	Damage (Any one		
					Med	Exp (Any one person)	,	
	Automobile Liability Deductible Comp and Coll: Any auto				(Each	nbined Single Limit Accident) regate		
Х	Workers' Compensation & Employers' Liability	7/1/2020	7/1/20	21	х	Statutory	\$2,000,000	
					Eacl	n Accident	\$2,000,000	
					Dise	ase – Each Employee		
					Dise	ase – Policy Limit		
	Property (Special Risk includes Fire and Theft)					ket Limit, Replacement (unless otherwise stated)	·	
Des	cription: Proof of Primex Member coverage only.							
CER	TIFICATE HOLDER: Additional Covered Party	Loss	Payoo	Prim		IH Public Risk Manage	mont Evolungo	
		LUSSI	чучч	1			เบอน ธระกสมชิธ	
				Ву:	7%	'ary Beth Purcell		
Stat	e of NH, Department of Health and Human Services			Date	: 10	0/20/2020 mpurcell@r	hprimex.org	
	Pleasant St					Please direct inquire	es to:	
Con	cord, NH 03301				Р	rimex ³ Claims/Coverag 603-225-2841 pho		

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.

- 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

Fire M. Movie

Name: Name: Morris

Title: Director, Division of Public Health Srvcs.

COUNTY OF MERRIMACK

12/18/2020

Date

Patrick Robinson

DocuSigned by:

Name Patrick Robinson

Title: Infection Prevention

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 \$449,700.00, for the number of test listed in Section 4.
- 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
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- 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.

1) Name of facility:



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

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

2) Have man	one Comment and a second Committee				
2) How many	y staff members does your facility	nave:			
3) Staff testii	ng lab utilized:				
4) Reimburse	ement type (please check all that a	 ipply):			
☐ Su	rveillance				•
	itbreak/Response				
	noreas/Response				
Co	ounty rate greater than 5%				
Co	ounty rate greater than 10%				
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident to	esting lab utilized (if different from	m staff and outles	only/seconomic about a	۸.	
o, resident to	some tab utilized (II different Ifo.	in starr and outbr	cak/response is enecked	<i>)</i> .	
					
		•			
Month for reimbu	rsement period: Select M	lonth			
violiti i i i i i i i i i i i i i i i i i i	ischient period. Jociect W	ionai			
Week 1 Test Date	Week 1 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement
	(if applicable)	Tested	(if applicable)	i	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	Total Staff	Residents Tested	Rate	Reimbursement
TYCER 5 TEST BUTC	(if applicable)	Tested	(if applicable)		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	Week 5 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement
(if applicable)	(if applicable)	Tested	(if applicable)		Amount
			<u> </u>	\$100/Test	
•					ne ne
Name		Title			Date 12/18/2
		•		Į (12/18/2

CERTIFICATE OF AUTHORITY

I. Marthew Lagas (Name of the elected Officer of the Corp.)	,	nereby certify that:
(Name of the elected Officer of the Corp	poration/LLC; cannot be contract	t signatory)
I am a duly elected Clerk/Secretary/Officer of	County of Mell Mary	DBF-Mellinacy County
	(Corporation/LLC Name)	noising Home
2. The following is a true copy of a vote taken at held on 9-39, 2020, at which (Date)	a quorum of the Directors/share	ctors/shareholders, duly called and cholders were present and voting.
VOTED: That Paticy Robinson, RY (Name and Title of Contract Sig	natory)	(may list more than one person)
is duly authorized on behalf of County of (Name of Corpo		tracts or agreements with the State
of New Hampshire and any of its agencies of documents, agreements and other instruments may in his/her judgment be desirable or necessa	, and any amendments, revision	ons, or modifications thereto, which
3. I hereby certify that said vote has not been a date of the contract/contract amendment to whethirty (30) days from the date of this Certificate New Hampshire will rely on this certificate as position(s) indicated and that they have full audimits on the authority of any listed individual to be all such limitations are expressly stated herein.	sich this certificate is attached. of Authority. I further certify that evidence that the person(s) lithority to bind the corporation.	This authority remains valid for t it is understood that the State of sted above currently occupy the To the extent that there are any
Dated: 12-18-20	(but)	
	Signature of El	
	Name: Matta	
	Title: / / //	



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 I	Number:		Compa	ny Affording	Coverage:	
Merrimack County 333 Daniel Webster Highway Suite 2 Boscawen, NH 03303	604			Bow 6 46 Do	Brook Plac Inovan Str	ce	change - Primex ³
Type of Coverage		ective Date m/dd/yyyy)	Expiration		Limits - Ņ	ł Statutory Limits	May Apply, If Not:
X General Liability (Occurrence Form) Professional Liability (describe) Claims Made Occurrence		/1/2020	1/1/202	21	fire)		\$ 5,000,000 \$ 5,000,000
Automobile Liability Deductible Comp and Coll: Any auto	-		14.		- 1	Single Limit	
X Workers' Compensation & Employer	s' Liability 1	/1/2020	1/1/202	21	X Stat	lutory	\$2,000,000
		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	11 11 201	- '	Each Acci	dent	\$2,000,000
					Disease -	Each Employee	·
					Disease -	Policy Limit	
Property (Special Risk includes Fire and	Theft)					it, Replacement s otherwise stated)	
Description: Proof of Primex Member cover	age only.		•				
CERTIFICATE HOLDER: Additional C	Covered Party	Lee- D		D-:-	.3 .0.1 6	Lilla Diata Mana	
CENTIFICATE HOLDER: Additional C	overed Party	Loss P	ayee	Prime	x – NH Pu	blic Risk Manage	ment Exchange
				Ву:	Mary Bo	th Purcell	
State of NH DHHS				Date:	10/27/20	020 mpurcell@nl	nprimex.org
129 Pleasant St Concord, NH 03301					Primex	lease direct inquire Claims/Coverage 603-225-2841 pho 603-228-3833 fa	e Services one

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.

Date

Date

- 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,

Department of Health and Human Services

12/18/2020

Department of Health and Human Services

Department of Health and Human Services

Department of Health and Human Services

Department of Health and Human Services

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Department of Health and Human Services

Department of Health and Human Services

Department of Health and

Administrator

Title:

State of New Hampshire

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.
- 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..

Date 12/18/2020



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

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

I) Name of f	acility:				
2) How many	y staff members does your facility	y have?			
3) Staff testin	ng lab utilized:				
4) Reimburse	ement type (please check all that	apply);			
☐ Su	rveillance				
Ou	utbreak/Response				
☐ Co	ounty rate greater than 5%				
c	ounty rate greater than 10%				
5) How many	residents does your facility have	e? (if outbreak/resp	oonse is checked)		
6) Resident to	esting lab utilized (if different fro	m staff and outbre	ak/response is checked) :	
Month for reimbu	rsement period: Select M	lonth			
Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
		-		¢100/7	

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	^ ∧ D ate	
		ישי ן	12/18/2020

CERTIFICATE OF AUTHORITY

1,	Joe Osgood,	hereby certify that:
	(Name of the elected Of	icer of the Corporation/LLC, wherethe contract signatory:

1. I am a duly elected Clerk/Secretary/Officer of Sullivan County Commissioners.

(Corporation/r.LC 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 <u>January 25, 2021</u> at which a quorum of the Directors/shareholders were present and voting.

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

is duly authorized on behalf of <u>Sullivan County Commissioners</u> to enter into contracts or agreements with the State (Name of Corporation (1.5.C)

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 1; 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 Footnote¹). 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 Footnote¹): 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

- December 2020/January 2021 Report (See Footnotel): 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 Footnote¹): 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 Jused 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 R\$As, 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 (Footnote¹). 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

 Joe Osopod. hereby certify that: (Name of the elected Efficient of the Corporation).) c. in mode to escalarly signatory.)

1. I am a duly elected Cierty/Secretary/Officer of Sulfivan County Commissioners.

 The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duty called and held on <u>January 23, 2021</u> at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Ted J. Purdy, Administrator (may list more than one person)
(Narron and Tatiu of Contract Separator)

is duly suthorized on behalf of <u>Suffiven County Commissioners</u> to enter into contracts or agreements with the State [Nation of Corpo Many 12.]

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, devisions, or modifications thereto, which netly in his/first judgment by deviatable or necessary to effect the purpose of this volt.

3. I hereby certify that eald vote has not been amended or repeated and remains in full horo and effect so of the date of the contractionstruct amendment to which this certificate is stached. 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 Hampethire will rely on this certificate as evidence that the person(s) issed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent this there are any limits on the surfactly of any listed individual to bind the corporation in contracts with the State of New Hampethire, all such firstletons are expressed states therein.

Dated: 1/25/2021

Name: 'Joe Oegood Tide: Clerk, Suttivan County Commissioners

Rev. 03/24/20

b. December 2020/January 2021 Reports (See Footnote¹): 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. <u>Employee 'Shoutout'</u>: County Manager (CM) Ferland noted that the SCHC nursing staff wanted to recognize **Amanda Tomasko of Central Supply** as site'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!
- COVID-19 Sullivan Strong Community Assistance Update: All viewed the report (See Footnote¹). 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. <u>State-County Finance Committee Update</u>: 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. <u>Legislative Items Update</u>: 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. <u>Economic Infrastructure Task Force</u>: 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. <u>HUD Lead Abatement Grant Project Update</u>: 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. <u>Sullivan County HUD Grant Program Policies: Lead Paint Abatement & Healthy Homes Policy; Motion Required:</u> 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:



Participating Member:

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.

Company Affording Coverage:

Member Number:

14 N	Main	County Street t, NH 03773		606		Bow 46 D	Brook Pl Onovan S		change - Primex ³
	•	Type of Co	verage	Effective Date (mm/dd/yyyy)	Expiration (mm/dd/y	Date		NH Statutory Limits	May Apply, If Not:
Х		eneral Liability (Occur		7/1/2020	7/1/20		Each O	ccurrence	\$ 5,000,000
		ofessional Liability (17112020	,,,,,	E 1	Genera	I Aggregate	\$ 5,000,000
i 		Claims Made	Occurrence				Fire Dar	mage (Any one	
							Med Ex	p (Any one person)	
· 		atomobile Liability eductible Comp and	d Coll:				Combin (Each Acc	ned Single Limit	
		Any auto					Aggrega	ate	
X	Wo	orkers' Compensatio	on & Employers' Liability	7/1/2020	7/1/202	<u></u> 21	x s	Statutory	\$2,000,000
							Each Ad	ccident	\$2,000,000
							Disease	9 — Each Employee	
							Disease	9 — Policy Limit	
	Pro	operty (Special Risk in	cludes Fire and Theft)					Limit, Replacement less otherwise stated)	
Desc	cript	tion: Proof of Primex	Member coverage only.						
CER	TIFIC	CATE HOLDER:	Additional Covered Party	Loss F	ayee	Prime	ex³ – NH ſ	 Public Risk Manager	ment Exchange
						Ву:		Eak Percell	
State		New Hompohire		<u> </u>		1	·		hadaan a
Depa 129	artm Plea	New Hampshire lent of Health and Hun asant Street , NH 03301	nan Services			Date:		6/2020 mpurcell@ni Please direct inquire ex³ Claims/Coverage 603-225-2841 pho 603-228-3833 fa	es to: e Services one

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.</p>
 - 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.

12/18/2020

12/18/2020

Date

Date

- 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.

State of New Hampshire

Title: Administrator

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

Department of Health and Human Services

Docusigned by:

Name: Name: Norris

Title: Director, Division of Public Health Srvcs.

THE EDGEWOOD MANOR INC

Docusigned by:

Patricia Cummings

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.
- 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.

1) Name of facility:



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

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

2) How many					
2, 110	staff members does your facility	have?			
3) Staff testir	ng lab utilized:				
4) Reimburse	ement type (please check all that a	apply):			
Su	rveillance				
Ou	ntbreak/Response				
Co	ounty rate greater than 5%				
Co	ounty rate greater than 10%				
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident to	esting lab utilized (if different from	m staff and outbr	cak/response is checked) :	
	•				
onth for reimbu	rsement period: Select M	lonth			
				·	
Veek 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
Veek 1 Test Date				Rate \$100/Test	
				<u> </u>	
	(if applicable) Week 2 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test	Amount Reimbursement
Veek 2 Test Date	(if applicable) Week 2 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate	Amount Reimbursement
Veek 2 Test Date	(if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date	Tested Total Staff Tested Total Staff	(if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement
Veek 2 Test Date Veek 3 Test Date	(if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date	Tested Total Staff Tested Total Staff	(if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement
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Veek 2 Test Date Veek 3 Test Date Veek 4 Test Date	(if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable) Week 5 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement Amount Reimbursement Amount
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Veek 2 Test Date Veek 3 Test Date Veek 4 Test Date	(if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable) Week 5 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement Amount Reimbursement Amount

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

Sccretary 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(les) 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). PHONE (AC, No, Ext): 855 874-0123 E-MAIL USI Insurance Services, LLC FAX (A/C, No): 877-775-0110 75 John Roberts Road, Building C AODRESS: South Portland, ME 04106 **INSURER(S) AFFORDING COVERAGE** NAIC # 855 874-0123 INSURER A: Medical Mutual Insurance Company of ME 36277 INSURED INSURER B : MEMIC Indemnity Co 11030 Edgewood Manor Inc. INSURER C : 928 South Street INSURER D : Portsmouth, NH 03801-5421 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. ADDL SUBRI TYPE OF INSURANCE POLICY EFF POLICY EXP (MM/DD/YYYY) (MM/DD/YYYY) POLICY NUMBER X COMMERCIAL GENERAL LIABILITY Α NHNHL004758 09/10/2020 09/10/2021 EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) CLAIMS-MADE X OCCUR \$100,000 \$5.000 MED EXP (Any one person) PERSONAL & ADV INJURY s 1,000,000 GENL'AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE \$3,000,000 POLICY Lioc PRODUCTS - COMP/OP AGG OTHER: COMBINED SINGLE LIMIT (Ea accident) AUTOMOBILE LIABILITY ANY AUTO BODILY INJURY (Per person) 5 SCHEDULED OWNED AUTOS ONLY BODILY INJURY (Per accident) S AUTOS NON-OWNED PROPERTY DAMAGE (Per accident) HIRED AUTOS ONLY AUTOS ONLY \$ UMBRELLA LIAB **OCCUR EACH OCCURRENCE** 4 **EXCESS LIAB** CLAIMS-MADE AGGREGATE RETENTION \$ WORKERS COMPENSATION OTH-ER 3102800456 09/10/2020 09/10/2021 X PER STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT \$500,000 N N/A (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE \$500,000 yes, describe under ESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT | \$500,000 NHNHL004758 09/10/2020 09/10/2021 Professional Liab \$1,000,000 Ea Incident Claims Made Basis \$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** CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE **Proof of Insurance** THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE

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.</p>
 - 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	Docusigned by: Tisat, M. Movvis
Date	Name:
	Title: Director, Division of Public Health Srvcs
	FRANKLIN HOME FOR THE AGED ASSOCIATION
	Cocusigned by:
1/12/2021	Mary E. Miller
Date	Name Name Prote Miller
	Title: Exective 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 \$29,000.00, for the number of test listed in Section 4.
- 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.
- 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.



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

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

1, 112119 57 11	acility:				
2) How many	y staff members does your facility	have?			
3) Staff testir	ng lab utilized:				
1) D. i., b.,					
4) Kelmburse	ement type (please check all that a	ibbih);			•
Su	rveillance				
Oı	utbreak/Response				
Co	ounty rate greater than 5%				
Co	ounty rate greater than 10%				
5) How many	y residents does your facility have	:? (if outbreak/res	ponse is checked)		
6) Resident to	esting lab utilized (if different fro	m staff and outbre	eak/response is checked):	
					•
onth for reimbu	rsement period: Select M	lonth			
	Week 1 Second Test Date	Total Staff	Residents Tested	<u> </u>	Reimbursement
Veek 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount
				\$100/Test	
Vanis 3 Tart Dat	Week 2 Second Test Date	Total Staff	Residents Tested	<u> </u>	Reimbursement
Veek 2 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount
_				\$100/Test	
/eek 3 Test Date	Week 3 Second Test Date	Total Staff	Residents Tested	Pata	Reimbursement
veek 3 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount
				\$100/Test	
	4——		U	u l	
Veek 4 Test Data	Week 4 Second Test Date	Total Staff	Residents Tested	Data	Reimbursement
Veek 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
Veek 4 Test Date				Rate \$100/Test	
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test	Amount Reimbursement
	(if applicable)	Tested	(if applicable)		Amount
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test	Amount Reimbursement
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate	Amount Reimbursement
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate	Amount Reimbursement
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate	Amount Reimbursement
Veek 5 Test Date	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate	Amount Reimbursement
Week 4 Test Date Week 5 Test Date (if applicable)	(if applicable) Week 5 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	\$100/Test Rate \$100/Test	Amount Reimbursement

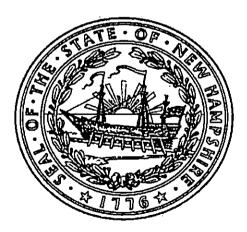
State of New Hampshire Department of State

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 1D: 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: __//_2/2/

Signature of Elected Officer
Name: Christopher Seufert

Title:

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). **USI Insurance Services LLC** PHONE (AJC, No, Ext): 855 874-0123 FAX (A/C, No): 3 Executive Park Drive, Suite 300 ADORESS: Bedford, NH 03110 INSURER(S) AFFORDING COVERAGE NAIC # 855 874-0123 INSURER A: Lexington Insurance Company 19437 INSURED INSURER B : AIM Mutual Insurance Company 33758 Franklin Home For The Aged Association INSURER C : American Alternative Insurance Corp 19720 dba Peabody Home INSURER D : 24 Peabody Place INSURER E : Franklin, NH 03235 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. ADDL SUBR POLICY EFF POLICY EXP (MM/DD/YYYY) (MM/DD/YYYY) TYPE OF INSURANCE POLICY NUMBER COMMERCIAL GENERAL LIABILITY Α SLG4NL800000300 03/13/2020 03/13/2021 \$1,000,000 **EACH OCCURRENCE** X CLAIMS-MADE DAMAGE TO RENTED PREMISES (Ea occurrence) OCCUR \$1,000,000 s15.000 MED EXP (Any one person) s 1.000.000 PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE s 3.000.000 \$3,000,000 PRODUCTS - COMP/OP AGG POLICY OTHER: 03/13/2020 03/13/2021 COMBINED SINGLE LIMIT AUTOMOBILE LIABILITY C SLHHHA105082901 \$1,000,000 X ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY BODILY INJURY (Per accident) s PROPERTY DAMAGE (Per accident) HIRED AUTOS ONLY Α UMBRELLA LIAB 03/13/2020 03/13/2021 EACH OCCURRENCE OCCUR SLG4NE900000400 \$1,000,000 **EXCESS LIAB** CLAIMS-MADE AGGREGATE \$1,000,000 DED | X RETENTION \$10000 WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ECC60040000272020A 06/01/2020 06/01/2021 X PER STATUTE IY PROPRIETOR/PARTNER/EXECUTIVE FICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT \$500,000 Ν (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE \$500,000 If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT | \$500,000 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** CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE State of New Hampshire THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. Dept. of Health & Human Services 129 Pleasant Street AUTHORIZED REPRESENTATIVE Concord, NH 03301

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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 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.</p>
 - 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.

Title:

Exhibit A-2, Amendment 1 Facility List

Project ID	Facility Name	Vendor (Address	City	State	Zip	buil TEST	Reimbursement Amount
SS-2021-DPHS-11-LONGT-11	Applewood	306096	8 Snow Road	Winchester	NH	03470	640	\$ 64,000.00
\$9-2021-DPHS-11-LONGT-11	Bedford Hills Center		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
	Crestwood	306497	40 Crosby Street	Milford	NH	03055	640	\$ 64,000.00
SS-2021-DPHS-11-LONGT-11		241721	290 Hanover St	Claremont	NH	03743	500	\$ 50,000,00
SS-2021-DPHS-11-LONGT-11		233419	8 Hampton Road	Exeter	NH	03833	760	\$ 76,000.00
\$5-2021-DPHS-11-LONGT-11		263830	191 Hackett Hill Road	Manchester	ЙH	03102	668	\$ 66,800,00
SS-2021-DPHS-11-LONGT-11		244265	20 Maitland Street	Concord	ИН	03301	704	\$ 70,400.00
\$\$-2021-DPHS-11-LONGT-11		244264	677 Court Street	Keene	NH	03431	832	\$ 63,200.00
\$8-2021-DPHS-11-LONGT-11	Laconia Rehabilitation Center	280154	175 Blueberry Lane	Laconia	NH	03246	1195	\$ 119,500,00
	Lafayette Center	244268	93 Main Street	Franconia	NH	03580	546	\$ 54,600,00
\$\$-2021-DPHS-11-LONGT-11		235654	60 Middle Road	Dover	NH	03820	760	\$ 76,000.00
68-2021-DPHS-11-LONGT-11		235658	136 1/2 Arch Street	Kaèna	NH	03431	810	\$ 81,000,00
\$5-2021-DPHS-11-LONGT-11		244240	24 Old Etna Road	Lebanon	NH	03766	1058	\$ 105,800,00
	Mineral Springs	231518	1251 White Mountain Highway	North Conway	ИН	03860	677	\$ 67,700.00
	Mountain Ridge Center	244266	7 Baldwin Street	Franklin	ΝН	03235	794	\$ 79,400.00
	Oceanside Skilled Nursing and Rehabilitation	241785	22 Tuck Road	Hampton	NH	03842	720	\$ 72,000.00
\$5-2021-DPH\$-11-LONGT-11		306498	50 Pheasant Road	Peterborough	NH	03458	762	\$ 76,200,00
	Pleasant View Center	244263	239 Pleasant Street	Concord	NH	03301	1152	\$ 115,200.00
65-2021-DPHS-11-LONGT-11		244241	25 Ridgewood Road	Bedford	NH	03110	988	\$ 98,800,00
SS-2021-DPHS-11-LONGT-11				Rochester	NH	03867	801	\$ 80,100,00
SS-2021-DPHS-11-LONGT-11		234295	1276 Hanover Street	Manchester	ин	03104	497	\$ 49,700.00
89-2021-DPH8-11-LONGT-11	Wolfeboro Bay Center	233423	39 Clipper Drive	Wolfebore	ин	03894	744	\$ 74,400.00
								\$ 1,795,600,00

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 MA



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

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

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 stuff and outbreak/response is checked):
	<u> </u>

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	

June Mores
Name

Title Cheartins

Date

CERTIFICATE OF AUTHORITY

Michael Berg I,Michael Berg, hereby certify that: (Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)
I am a duly elected Clerk/Secretary/Officer of <u>Genesis Administrative Services LLC</u> (Corporation/LLC Name)
 The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on <u>January 11,2021</u>, at which a quorum of the Directors/shareholders were present and voting. (Date)
VOTED: That <u>Lauren Murray. LNHA. Vice President Of Operations</u> (may list more than one person) (Name and Title of Contract Signatory)
s duly authorized on behalf of <u>Genesis Administrative Services LLC</u> to enter into contracts or agreements with (Name of Corporation/ LLC)
he 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.
B. 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



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 REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED 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 CONTACT NAME: PHONE (A/C. No. Ext); E-MAIL FAX (A/C, No): 99 HIGH STREET BOSTON, MA 02110 ADDRESS: INSURER(S) AFFORDING COVERAGE NAIC # CN130089801-STND-GAWP-20-21 14484 INSURER A: Hudson Excess Insurance Company Genesis Healthcare, Inc. 23035 INSURER 8: Liberty Mutual Fire Insurance Co. 101 East State Street 19399 INSURER C : AIU Insurance Co. Kennett Square, PA 19348 INSURER D: INSURER E : INSURER F : **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. ADDL SUBR POLICY EFF POLICY EXP
(MM/DD/YYYY) (MM/DD/YYYY) TYPE OF INSURANCE POLICY NUMBER LIMITS HFF100067-2005 COMMERCIAL GENERAL LIABILITY 12/01/2020 12/01/2021 3,000,000 **EACH OCCURRENCE** DAMAGE TO RENTED PREMISES (Ea occurrence) X CLAIMS-MADE OCCUR 3,000,000 **EXCLUDED** MED EXP (Any one person) 3,000,000 PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: 3,000,000 GENERAL AGGREGATE \$ X POLICY 3,000,000 PRODUCTS - COMP/OP AGG \$ OTHER: S В AS2-631-004097-340 COMBINED SINGLE LIMIT **AUTOMOBILE LIABILITY** 12/01/2020 12/01/2021 \$ 1,000,000 SIR: \$250,000 ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED BODILY INJURY (Per accident) \$ AUTOS NON-OWNED PROPERTY DAMAGE (Per accident) Χ HIRED AUTOS ONLY \$ AUTOS ONLY \$ **UMBRELLA LIAB OCCUR EACH OCCURRENCE** \$ EXCESS LIAB CLAIMS-MADE **AGGREGATE** DED RETENTION \$ WORKERS COMPENSATION 045886637 (AOS) 11/15/2020 02/15/2021 X | PERTUTE AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below Deductible:\$1,500,000 1,000,000 E.L. EACH ACCIDENT N N/A (Continued on Acord 101) 1,000,000 E.L. DISEASE - EA EMPLOYEE 1,000,000 E.L. DISEASE - POLICY LIMIT Medical Professional Liability 3,000,000 HFF100067-2005 12/01/2020 12/01/2021 Each Medical Incident: 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** CANCELLATION 7 Baldwin Street Operations LLC SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE d/b/a Mountain Ridge Center THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN 7 Baldwin Street ACCORDANCE WITH THE POLICY PROVISIONS. Franklin, NH 3235 AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Michael, P. Walsh

AGENCY CUSTOMER ID: CN130089801

LOC #: Boston



ADDITIONAL REMARKS SCHEDULE

Page 2 of 2

AGENCY	<u>.</u>	NAMED INSURED		
MARSH USA, INC. POLICY NUMBER		Genesis Healthcare, Inc. 101 East State Street Kennett Square, PA 19348		
CARRIER	NAIC CODE	-[
		EFFECTIVE DATE:		
ADDITIONAL REMARKS	-			

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM TITLE: Certificate of Liability Insurance FORM NUMBER:

Other WC policies:

States covered: CA

Carrier: American Home Assurance Company

Policy Number: 045886640

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: AlU 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

Employers Liability Each Accident: \$1,000,000 Employers Liability Disease-Policy Limit: \$1,000,000

Self insured retention: \$1,500,000

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.</p>
 - 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.

State of New Hampshire

President

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

Department of Health and Human Services

12/18/2020

Date

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

GREENLEAF PROPERTIES INC

12/18/2020

Date

Docusigned by:

Unstoplus Martin

Name: Christopher Martin

Title:

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

- 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.

Date 12/18/2020



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 f	ballien.				
1) Pame of t	acmy.				
2) How many	y staff members does your facility	have?			•
3) Staff testin	ng lab utilized:				
4) Reimburse	ement type (please check all that a	 ipply):			
Su	rveillance				
O.	utbreak/Response				
	ounty rate greater than 5%				
	· · · · · · · · · · · · · · · · · · ·				
Co	ounty rate greater than 10%				
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident to	esting lab utilized (if different fro	m staff and outbre	eak/response is checked) .	
,	<u> </u>		and to post to the total to	,.	
NA					
Month for reimbu	rsement period: Select M	ionth			
	Week 1 Second Test Date	Total Staff	Residents Tested	 -	Reimbursement
Week 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	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	Total Staff	Residents Tested	Rate	Reimbursement

Tested

Total Staff

Tested

Total Staff

Tested

(if applicable)

Week 4 Second Test Date

(if applicable)

Week 5 Second Test Date

(if applicable)

Week 4 Test Date

Week 5 Test Date

(if applicable)

		os	
Name	Title	(M Date	12/18/2020

(if applicable)

Residents Tested

(if applicable)

Residents Tested

(if applicable)

Rate

\$100/Test

Rate

\$100/Test

Rate

\$100/Test

Amount

Reimbursement

Amount

Reimbursement

Amount

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

1, _	
	I am the sole shareholder and director of <u>Grentlet Pwperi ES</u> On <u>13/23/20</u> (date); <u>Christipher Marrix</u> (name), the sole shareholder and director of
\mathcal{C}	(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 Marin (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.
	la de la como M-t
ated:	12/23/20 Wyth Walten (Name of Sole Shareholder and Director)
	Accession as a contract asset as a contract asset as a contract as a contract as a contract as a contract as a

DocuSign Envelope ID: F71B2113-DL	211-43B3-B60A-1337EE1819F1		GRI	EPROP5			
ACORD. INSUI	RANCE BINDER					DATE 09/04/20	Ē
THIS BINDER IS A TEMPORARY	INSURANCE CONTRACT, SUBJECT	TO THE CONDITION	NS SHOW	N ON THE RI	EVERSE SI	IDE OF THIS	FORM.
PRODUCER PHONE (A/C, N. FAX (A/C, N. (A	o. Ext): 253.761.3256	COMPANY			BINDER	3.0	
FAX (A/C No	253.761.3256	Allied Property and C	asualty Ins.	С	ACP3	047817483	j
Propel Insurance	<u> </u>	DATE	TIVE	TIME	DAT	EXPIRATION	TIME
Commercial Insurance		DATE		X AM	DA		(12:01 A
1201 Pacific Ave, Suite 1000		10/25/20	12:01	\vdash	12/25/20	- <u>-</u>	
•				РМ	l		МООМ
Tacoma, WA 98402		THIS BINDER IS	ISSUED TO EX	CTEND COVERAGE	IN THE ABOV	E NAMED COMP	PANY
CODE:	SUB COOE:	PER EXPIRING P		<u> </u>			
AGENCY CUSTOMER ID: 186742		DESCRIPTION OF OPER	ATIONS/VEHI	CLES/PROPERTY (Including Loc	ation)	
INSURED Greenleaf Propert	ties, Inc.	Veh#1: 2012 Dod	ige Ram 2	2500 Truck			
dba Woodlawn Ca	are Center	3C6LD5AT4CG1	88097 NH				
84 Pine Street		Veh#2: 2014 Dod	ige Ram I	Promaster Va	an n		
Newport, NH 037	73-2005	3C6TRVPG5EE1	24628 NH				
,	. 0 2000	(See Special Cor					
COVERAGES	· · · · · · · · · · · · · · · · · · ·	Tooc obeciai coi	TOTAL CONTRACT	0.011,	1 45.61		
· · · · · · · · · · · · · · · · · · ·	1			1	LIMI		
TYPE OF INSURANCE	COVERAGE/FORM			DEDUCTIBLE	COINS %	AMOL	
PROPERTY CAUSES OF LOSS	Blanket 1: Combined Bldg & Per F	•		Varies	100	\$5,624,72	.2
BASIC BROAD X SPEC	Blanket 2: BI/EE Incl Rental Value	!		72 Hours	100	\$1,929,30	0
X RCV						1	
X Agreed Value	See Spec. Conditions/Other Cover	ages					
GENERAL LIABILITY				EACH OCCURRE	NCF	s 1,000,00	20
X COMMERCIAL GENERAL LIABILITY				DAMAGE TO		\$ 100,000	
				RENTED PREMI			
CLAIMS MADE OCCUR				MED EXP (Any or		s 5,000	
 				PERSONAL & AE	OV INJURY	s 1,000,00	
	See Spec. Conditions/Other Cover	ages		GENERAL AGGE	EGATE	\$ 3,000,00	<u> </u>
	RETRO DATE FOR CLAIMS MADE: 10/25/200)5		PRODUCTS - CC	MP/OP AGG	s 3,000,00	<u> </u>
AUTOMOBILE LIABILITY				COMBINED SING	SLE LIMIT	\$ 1,000,00	00
X ANY AUTO				BODILY INJURY	(Per person)	s	
ALL OWNED AUTOS				BODILY INJURY	(Per accident)	s	
SCHEDULED AUTOS				PROPERTY DAM	· · · · · ·	\$	
HIRED AUTOS				MEDICAL PAYM		\$ 5.000	
NON-OWNED AUTOS	•					1	
NON-OWNED AUTOS				PERSONAL INJU		\$	
 				UNINSURED MO	TORIST	s 1,000,00) 0
	<u> </u>					\$	
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X COLLISION: 1000				STATED A	MOUNT	_ s	
X OTHER THAN COL: 1000				OTHER			
GARAGE LIABILITY	,			AUTO ONLY - EA	ACCIDENT	s	
ANY AUTO	·			OTHER THAN AL		1	
					ACCIDENT	<u>s</u>	
	i					<u> </u>	
EXCESS LIABILITY					GGREGATE	- 	20
				EACH OCCURRE	NÇE	s 1,000,00	
X UMBRELLA FORM	40,000			AGGREGATE		s 1,000,00	טנ
OTHER THAN UMBRELLA FORM	RETRO DATE FOR CLAIMS MADE: 10/25/05		•	SELF-INSURED	RETENTION	5	
				WC STATE	JTORY LIMITS	<u> </u>	
WORKER'S COMPENSATION				E.L. EACH ACCIO	DENT	5	
AND EMPLOYER'S LIABILITY	l ,			E.L. DISEASE - E	A EMPLOYEE	5	
				E.L. DISEASE - P	OLICY LIMIT	s	
Named Insureds:		, ,		FEES	<u> </u>	s	
CONDITIONS/ ag Di	alic						
OTHER OO I IIIO OCIIIOI EIVIN	Conditions/Other Covs page.)			TAXES		\$.	
	Conditions/Other Covs page.)			ESTIMATED TOT	AL PREMIUM	\$	
NAME & ADDRESS			, ,				
	}	MORTGAGEE LOSS PAYEE	ADO	ITIONAL INSURED			
		LOAN#	1				
	Ì	ALITHODIZEO REDRECEN	TATRIE				
		AUTHORIZED REPRESEN	TANAE				

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.

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



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 Holder

Certificate of Insurance

Chris Martin
Greenleaf Properties, Inc.

84 Pine Street
Newport, NH 03773

Company Letter A

Company Letter A

Company Letter B

Midwest Employers Casualty Corp.

This policy is effective at 12:00 am on 02/01/2020, and will expire at 12:01 am on 02/01/2021.

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	HCH\$20200000216	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 Operation	ns			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.

Oct 27, 2020

- Authorized Representative

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.</p>
 - 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	Docysigned by: Then M. Morris
Date	Name: Morris
	Title: Director, Division of Public Health Srvcs.
	HANOVER HILL HEALTH CARE CENTER SERVICES
·	DocuSigned by:
12/28/2020	Loni Molutine
Date	Name: Name:
	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.

Date 12/28/2020



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

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

Staff testing Reimburser	ment type (please check all that ap	oply):				
_	veillance					
	tbreak/Response					
_	unty rate greater than 5% unty rate greater than 10%					
	residents does your facility have	? (if outbreak/resp	ponse is checked)			
6) Resident te	sting lab utilized (if different from	n staff and outbre	eak/response is checked) (
	 -					
nth for reimbu	sement period: Select M	onth				
	rsement period: Select M	onth Total Staff	Residents Tested	Page 1	Reimbursement]
			Residents Tested (if applicable)	Rate	Reimbursement Amount	
	Week 1 Second Test Date (if applicable)	Total Staff Tested	(if applicable)	Rate \$100/Test	Amount	
ek 1 Test Date	Week 1 Second Test Date	Total Staff				, , , , , , , , , , , , , , , , , , ,
ek 1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date	Total Staff Tested Total Staff	(if applicable) Residents Tested	\$100/Test	Amount Reimbursement	
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nth for reimburek 1 Test Date eek 2 Test Date eek 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date	Total Staff Tested Total Staff Tested Total Staff	(if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test Rate \$100/Test Rate	Amount Reimbursement Amount Reimbursement	
ek 1 Test Date ek 2 Test Date ek 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement Amount Reimbursement	
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12/28/2020

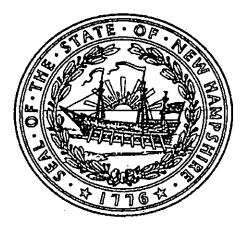
State of New Hampshire Department of State

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: 1/5/2/

Signature of Elected Officer

Name

Rev. 03/24/20

ACORD'

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). CONTACT NAME: Carrie Morgan PHONE (A/C. No. Ext): E-MAIL ADDRESS: (603) 669-3218 FAX (A/C, No): (603) 645-4331 FIAI/Cross Insurance cmorgan@crossagency.com 1100 Elm Street INSURER(S) AFFORDING COVERAGE NAIC # NH 03101 Medical Mutual Insurance Co of Maine Manchester INSURER A: The Travelers Indemnity Co. & its Affiliates. INSURED INSURER B : 13083 New Hampshire Employers Ins Co Hanover Hill Health Care Center Services Inc. INSURER C : 700 Hanover Street INSURER D INSURER E : NH 03104 Manchester INSURER F : **CERTIFICATE NUMBER:** 20-21 All Lines **REVISION NUMBER: COVERAGES** 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.

EX	(CLUSIONS AND CONDITIONS OF SUCH POL			ITS SHOWN MAY HAVE BEEN REDUC				
INSR LTR	TYPE OF INSURANCE	ADDLS	UBR WVD	POLICY NUMBER	PÓLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMIT	-
	COMMERCIAL GENERAL LIABILITY							s 1,000,000
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	s 100,000
							MED EXP (Any one person)	s 5,000
Α				NH NHL 004352	12/01/2020	12/01/2021	PERSONAL & ADV INJURY	s 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:							\$ 3,000,000
	POLICY PRO- LOC	ŀ					PRODUCTS - COMP/OP AGG	s 1,000,000
	OTHER: Professional Liability						Each Occur/Aggregate	s 1 mill / 3 mill
	AUTOMOBILE LIABILITY	T					COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
	X ANY AUTO	-					BODILY INJURY (Per person)	\$
В	OWNED SCHEDULED AUTOS ONLY AUTOS	1		BA-4R751664-20-43-G	12/01/2020	12/01/2021	BOOILY INJURY (Per accident)	\$
i	HIRED NON-OWNED AUTOS ONLY				!		PROPERTY DAMAGE (Per accident)	\$
							Uninsured motorist	\$ 1,000,000
	UMBRELLA LIAB X OCCUR			•			EACH OCCURRENCE	s 2,000,000
Α	EXCESS LIAB CLAIMS-MADE	Į		NH UMB 004353	12/01/2020	12/01/2021	AGGREGATE	\$ 2,000,000
	DED X RETENTION \$ 10,000							s
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						➤ PER STATUTE ER	
_	ANY PROPRIETOR/PARTNER/EXECUTIVE	N/A		ECC60040001082020 (3a.) NH	12/31/2020	12/31/2021	E.L. EACH ACCIDENT	s 500,000
ľ	(Mandatory in NH)	","		25355 (555) 552520 (553)	1		E.L. DISEASE - EA EMPLOYEE	\$ 500,000
l	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	ş 500,000
С	Theodore & Deborah Chamberlain Lee excluded from workers compensation							
	CRIPTION OF OPERATIONS / LOCATIONS / VEHICLE	S /AC	OPD 1	01 Additional Pamarka Schadula, may be	ttached if more as	nace is required)		
DESC	CKIP HON OF OPERATIONS / COCATIONS / VEHICLE:	S (ACI	UKU 1	VI, AUGUUMBI NYIHBIKS SCHWUMF, HBY DE I	mayres ir more s	hara is isdinish)		

CERTIFICATE HOLDER		CANCELLATION					
New Hampshire Department of Hea	alth & Human Services	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.					
Bureau of Contracts & Procurem		AUTHORIZED REPRESENTATIVE					
129 Pleasant Street							
Concord	NH 03301	Jalitha Jeongero					

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.

12/23/2020

12/23/2020

Date

Date

- 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,

Title:

NHA

Department of Health and Human Services

Docusioned by:

Name:
Name:
Name:
Title: Director, Division of Public Health Srvcs.

HEARTLAND HEALTHCARE CENTER LLC

Docusioned by:
Maldin Dean

State of New Hampshire

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 \$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.



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 fa	cility:					
2) How many	staff members does your facility	have?				
3) Staff testing	a lab utilizad					
5) Statt testing	g lab utinzed.					
4) Reimburser	ment type (please check all that a	pply):				
Sur	veillance					
Ou	tbreak/Response					
Co	unty rate greater than 5%					
Co.	unty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
	sting lab utilized (if different from					
6) Kesident le	sting lab utilized (if different from	n starr and outore	eak/response is enecked)			
<u> </u>		 _				
	Colock M					
onth for reimbui	rsement period: Select M	ontn _				
Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
				\$100/Test		
Veek 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
				\$100/Test		
Veek 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	
<u> </u>				\$100/Test		
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Search Business Names

Back to Home (/online/BusinessInquire)

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Business Name	Business ID	Homestate Name	Previous Name	Business Type	Principal Office Address	Registered Agent Name	Status
Heartland HealthCare Center, LLC Yonline/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						·	
						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Bac

CERTIFICATE OF AUTHORITY

Allison Burwin 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

DocuSi A	gn Envelope ID: F098A54B-D4F2-4 COKD7M DEIGO	312-B782-D67F624890B0	ABULIT	YINSU	RANCE D	ATE (MM/DD/YY) 12/30/2019			
	USA Risk Group (Cayman LTD.) (877) 483-1850 P. O. Box 1085, Queensgate House, 5th Floor Grand Cayman, KY1-1102		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.						
	Cayman Íslands		INSURERS AFFORDING COVERAGE						
INSU	IRED		INSURER A; Prei	INSURER A: Premier Plus Insurance Company, LTD					
1	National HealthCare Corporatio	n	INSURER B:						
	00 E. Vine Street		INSURER C:						
'	Murfreesboro, TN 37130		INSURER D:						
			INSURER E:	45.1					
THE P	ERAGES This Certificate is not int OLICIES OF INSURANCE LISTED BELOW HAD ONDITION OF ANY CONTRACT OR OTHER DO RIBED HEREIN IS SUBJECT TO ALL THE TERN	VE BEEN ISSUED TO THE INSURED NAME CUMENT WITH RESPECT TO WHICH THIS	D ABOVE FOR THE POLICY S CERTIFICATE MAY BE IS:	Y PERIOD INDICATED, N SUED OR MAY PERTAIN	NOTWITHSTANDING ANY REQU T, THE INSURANCE AFFORDED B	IREMENT, TERM Y THE POLICIES			
INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DDAYY)	POLICY EXPIRATION DATE (MMIDDITY	ı.	IMITS			
	GENERAL LIABILITY				EACH OCCURRENCE	1,000,000.			
	COMMERCIAL GENERAL LIABILITY	PP 019	01/01/2020	01/01/2021	FIRE DAMAGE (Any one fire)	50,000.			
A	CLAIMS MADE OCCUR		01/01/2020	0170172021	MED EXP (Any one person)	Excluded			
	Professional Liability Premises Liability				PERSONAL & ADV INJURY	Included			
	GEN'L AGGREGATE LIMIT APPLIES PER:	, ·			GENERAL AGGREGATE	3,000,000.			
	POLICY PRO- LOC				PRODUCTS - COMP/OP AGG	N/A			
					NO Deductible Appl	ie			
	AUTOMOBILE LIABILITY ANY AUTO				COMBINED SINGLE LIMIT (Each accident)				
	ALL OWNED AUTOS SCHEDULED AUTOS				BODILY INJURY (Per person)				
	HIRED AUTOS NON OWNED AUTOS				BODILY INJURY (Per accident)				
	\$1000 Ded, Collision \$250 Ded Comp				.PROPERTY DAMAGE (Per accident)				
	GARAGE LIABILITY				AUTO ONLY - EACH ACCIDENT				
	ANY AUTO				OTHER THAN EA ACC				
					AUTO ONLY: AGG				
	EXCESS LIABILITY				EACH OCCURRENCE				
	OCCUR CLAIMS MADE				AGGREGATE	1			
	DEDUCTIBLE					1			
	RETENTION \$ 0					† .			
	WORKERS' COMPENSATION AND	100010:::5	01/01/2000	01/01/2021	WC STATU- OTH-	1 _			
A	EMPLOYERS' LIABILITY	10804014-15	01/01/2020	01/01/2021	E.L. EACH ACCIDENT	1,000,000			
					E.L. DISEASE-POLICY LIMIT	1,000,000			
<u></u>					E.L. DISEASE-EA EMPLOYEE	1,000,000			
	OTHER								
1	ription of operations/locations/veh vidence of Insurance - Hea				Care Center				
CER	RTIFICATE HOLDER		CANCELLATI	ON					
129	partment of Health and Human Pleasant Street ncord, NH 03301	Services	SHOULD ANY OF THE THEROF, THE ISSUING CERTIFICATE HOLDER	ABOVE DESCRIBED POI COMPANY WILL ENDE NAMED TO THE LEFT.	LICIES BE CANCELED BEFORE T AVOR TO MAIL 30 DAYS WRITT BUT FAILURE TO DO SO SHALL ANY, ITS AGENTS OR REPRESE:	EN NOTICE TO THE . IMPOSE NO OBLIGATION			
1			AUTHORIZED REPRESE	NTATIVE Paul N	/acev				
ACC	ORD 25-S (7/97)				ACORD CORPORA	TION 1988			

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.</p>
 - 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.

- Occusioned by:

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	Fre M. Morrie
Date	Name: Name: Morris
•	Title: Director, Division of Public Health Srvcs.
	HOLY CROSS HEALTH CENTER INC
	DocuSigned by:
12/29/2020	Scott M. Watkiewicz
Date	Name: Suceto M. Wojtkiewicz
	Titlo:

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.
- 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.



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 fa	cility:			·	
2) How many	staff members does your facility	have?			
3) Staff testing	g lab utilized:				
. 4) Reimburse	ment type (please check all that a	pply):			
				-	
Sur	rveillance				
Ou	tbreak/Response				
Co	unty rate greater than 5%				
☐ Co	unty rate greater than 10%				
5) How many	residents does your facility have	? (if outbreak/rest	oonse is checked)		
6) Resident te	sting lab utilized (if different from	n staff and outbre	ak/response is checked)):	
		· _			
	rsement period: Select M	onth Total Staff	Residents Tested		Reimbursement
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12/29/2020

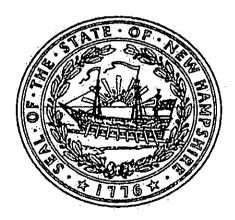
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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

- 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 <u>Scott Woltkiewicz</u>

(may list more than one person)

(Name and Title of Contract Signatory)

is duly authorized on behalf of <u>Holy Cross Health Center, Inc.</u> 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



CERTIFICATE OF LIABILITY INSURANCE

DATE (MN/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.

REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER. IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(les) 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 fleu of such endorsement(s). CONTACT NAME: PHONE (A/C, No. Ext): 831-423-9500 846AIL Waldorf Risk Solutions, LLC PAX, Ho); 631-424-3610 PO Box 590 AODRESS: Info@wrs1928.com **Huntington NY 11743** INSURER(S) AFFORDING COVERAGE INSURER A: Certain Underwriters at Lloyds, London - AA1122000 HOLSIS INSURED INSURER B Holy Cross Health Center INSURER C 357 Island Pond Road Manchester, NH 03109 INSURER D NSURER E INSURER F **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. ADDI SUBR POLICY EFF POLICY EXP TYPE OF INSURANCE **POLICY NUMBER** LTR Х COMMERCIAL GENERAL LIABILITY 20W1481 7/1/2020 7/1/2021 EACH OCCURRENCE DAMAGE TO RENTED PREMISES (En pocurrence) \$ 1,000,000 CLAIMS-MADE X OCCUR MED EXP (Any one person) PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE \$ 2,000,000 Х JECT PRO-POLICY | Loc PRODUCTS - COMPJOP AGG OTHER OMBINED SINGLE LIMIT AUTOMOBILE LIABILITY \$ (Ea accident ANY AUTO SOOILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS NON-OWNED **BODILY INJURY (Per accident)** HIRED AUTOS ONLY PROPERTY DAMAGE (Per accident) AUTOS ONLY IMBREI LA LIAR 20XS103 7/1/2020 7/1/2021 OCCUR EACH OCCURRENCE \$ 1,000,000 х EXCESS LIAB CLAIMS-MADE AGGREGATE \$ 1,000,000 DED -RETENTION WORKERS COMPENSATION AND EMPLOYERS' LIABILITY PER STATUTE ANYPROPRIETORIPARTNER/EXECUTIVE
OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT (Mandatory in NH) E.L. DISEASE - EÁ EMPLOYER If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT Professional Liability 20W1481 \$1,000,000 7/1/2020 7/1/2021 Per Claim: 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 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. Dept. of Health and Human Services 129 Pleasant street AUTHORIZED REPRESENTATIVE Concord NH 03301

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Client#: 491562

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ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (NIM/OD/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(les) 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). CONTACT NAME: PRODUCER NAME: PHONE (A/C, No, Ext): 855 874-0123 E-MAIL **USI Insurance Services LLC** 3 Executive Park Drive, Suite 300 AODRESS: Bedford, NH 03110 INSURER(8) AFFORDING COVERAGE 855 874-0123 33758 INSURER A : AIM Mutual Insurance Company INSURED INSURER B :

Holy Cross Health Care C	enter, Inc	•	INSURER C:						
357 Island Pond Road			INSURER D:						
Manchester, NH 03109			INSURER E:						
	_		INSURER F :						
COVERAGES CER	VERAGES CERTIFICATE NUMBER:				REVISION NUMBER:				
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© 1988-2015 ACORD CORPORATION. All rights reserved.

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.</p>
 - 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.

State of New Hampshire

Administrator

Department of Health and Human Services

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

Date

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Title:

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 \$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.



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

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

2) How many	staff members does your facility	have?				
3) Staff testin	ig lab utilized:					
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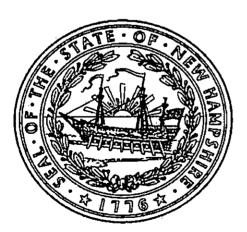
State of New Hampshire Department of State

CERTIFICATE

1, 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 Demoration/LL	oanint be contract signatury
1. I am a duly elected Clerk/Secretary/Officer ofJaffrey Corporat	Rehabilitation and Nursing Center LLC on/LLO Name,
2. The following is a true copy of a vote taken at a meeting held on	of the Board of Directors/shareholders, duly called and which a quorum of the Directors/shareholders were
VOTED: ThatPatrick Lyons_Administrator	(may list more than
one person) (Name and Title of Contract Signatory)	
is duly authorized on behalf of Jaffrey Rehabilitation at agreements with the State (Name of Corporation/ LL)	
of New Hampshire and any of its agencies or departm documents, agreements and other instruments, and any may in his/her judgment be desirable or necessary to effect	amendments, revisions, or modifications thereto, which
3. I hereby certify that said vote has not been amended of date of the contract/contract amendment to which this certifity (30) days from the date of this Certificate of Authoriting New Hampshire will rely on this certificate as evidence position(s) indicated and that they have full authority to limits on the authority of any listed individual to bind the coall such limitations are expressly stated herein.	ertificate is attached. This authority remains valid for ty, I further certify that it is understood that the State of that the person(s) listed above currently occupy the pind the corporation. To the extent that there are any
Dated:12/18/2020	Signature of Elected Officer Name: Akira Horowitz Title: Managing Member

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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.</p>
 - 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.

State of New Hampshire

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

Department of Health and Human Services

12/21/2020

Date

Docusioned by:

Name:

Name:

Director, Division of Public Health Srvcs.

MEMORIAL ELDER HEALTH SERVICES

12/21/2020

Date

Docusioned by:

Name:

Name:

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Name:

Name:

Director, Division of Public Health Srvcs.

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 \$ 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
<u> </u>	

- 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.

nitials 12/21/2020

1) Name of facility:



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

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

3) Staff testing lab utilized: 4) Reimbursement type (please check all that apply): Surveillance	2) How many		l l				
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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 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



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 Chair, Board of Trustees

May B DeVian

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 Develue Board of Trustees Chair

6/17/2020

Date

(Corporate Seal)



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.

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). CONTAC PHONE (A/C. No. Ext): E-MAIL FAX No): 2075238320 2077752791 Medical Mutual Insurance Company of Maine One City Center PO Box 15275 ADDRESS: Portland, ME 04112 INSURER(S) AFFORDING COVERAGE INSURER A: Medical Mutual Ins Co of Maine INSURED INSURER B: Medical Mutual Ins Co of Maine Memorial Hospital INSURER C : 3073 White Mountain Highway INSURER D : INSURER E : North Conway NH 03860 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. ADDLISUBR POLICY EFF | POLICY EXP (MM/DD/YYYY) | (MM/DD/YYYY) LIMITS TYPE OF INSURANCE POLICY NUMBER COMMERCIAL GENERAL LIABILITY 2,000,000 **EACH OCCURRENCE** Α NH HPL 004270 10/01/2020/10/01/2021 DAMAGE TO RENTED PREMISES (Ea occurrence) 100,000 CLAIMS-MADE X OCCUR 5,000 MED EXP (Any one person) 2,000,000 PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: 4,000,000 GENERAL AGGREGATE POLICY PRO. LOC 2,000,000 PRODUCTS - COMP/OP AGG 5 OTHER: OMBINED SINGLE LIMIT AUTOMOBILE LIABILITY (Ea accident) BODILY INJURY (Per person) ANY AUTO SCHEDULED AUTOS NON-OWNED AUTOS ALL OWNED BODILY INJURY (Per accident) | \$ PROPERTY DAMAGE \$ HIRED AUTOS (Per accident) 5 UMBRELLA LIAS EACH OCCURRENCE OCCUR **EXCESS LIAB** AGGREGATE CLAIMS-MADE DED RETENTION \$ WORKERS COMPENSATION AND EMPLOYERS' LIABILITY STATUTE ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE \$ If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT | \$ 10/01/2020 10/01/2021 \$2,000,000/\$4,000,000 **Professional Liability** NH HPL 004270 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 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. State of New Hampshire Department of Health and Human Services 129 Pleasant Street AUTHORIZED REPRESENTATIVE Frank W Laine Concord, NH 03301

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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

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	129 Pleasant Street Concord, NH 03301				AUTHO	RIZED REPRESE	NTATIVE 3		

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

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: \$1,986,800
- 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:
 - 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.</p>
 - 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.

Date

Date

- 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.

State of New Hampshire

Department of Health and Human Services

Chief Executive Officer

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

12/31/2020 Manne Bis Ste M. Morris Director, Division of Public Health Srvcs. MERRIMAC MEDICAL INVESTORS LLC DocuSigned by: 12/30/2020 Stephan Parulski NaffgggtをMan Pazulski

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 \$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.

Name of facility:



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

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

	staff members does your facility	have?				
3) Staff testin	g lab utilized:					
4) Reimburse	ment type (please check all that a	pply):				
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_ 	tbreak/Response					
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_	unty rate greater than 5%				·	
Ŭ C₀	unty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/resp	ponse is checked)			
6) Resident to	sting lab utilized (if different from	n staff and outbro	eak/response is checked)) :		
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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

O THE STATE OF THE

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

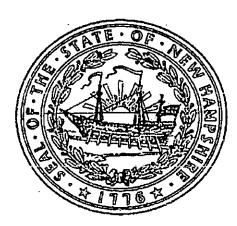
State of New Hampshire Department of State

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 1D: 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

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(3) Whereby certify that said vote has not been	lamendedlor repealed and remains in full force and effect as of the
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dimits on the authority of any listed individual (to all such limitations are expressly stated herein	Old Inditing Corporation in Icontracts with the Istate Milliand Indiana in the Istate of Indiana in
Dated 2 17 2021	
	Signature of 'Elected Officer' Name Trackle Thomas
	Waya Wa Mayba

OP ID: AL

ACORD'

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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(les) 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). CONTACT 703-359-8100 703-359-8100 Hamilton Insurance Agency PHONE 703-359-8100 FAX (A/C, No): 703-359-8108 Alan J. Zuccari, Inc. E-MAIL ADDRESS: aeagle@hamiltoninsurance.com 4100 Monument Corner Dr. #500 Fairfax, VA 22030 INSURER(S) AFFORDING COVERAGE NAIC # INSURER A: Columbia Casualty Co. INSURER B : Continental Insurance Company INSURED Merrimac Medical Investors LLC Us Fairview Nursing Center! Laurel Place Assisted Living! The Inn at Fairview 203 Lowell Road Hudson, NH 03051 INSURER C . Technology Insurance Company INSURER D : American Cas Co of Reading PA 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 ADOL SUBR POLICY EFF POLICY EXP TYPE OF INSURANCE POLICY NUMBER LIMITS X COMMERCIAL GENERAL LIABILITY 1.000.000 EACH OCCURRENCE 100,000 X CLAIMS-MADE DAMAGE TO RENTED PREMISES (Ea occurrence) OCCUR 4022871694 07/01/2020 07/01/2021 Prof Liab \$1M/\$3M 5.000 MED EXP (Any one person) \$25,000 DED 1.000.000 PERSONAL & ADV INJURY 3,000,000 GENT AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE Included PEC. POLICY LOC PRODUCTS - COMP/OP AGG Emp Ben. Included OTHER: COMBINED SINGLE LIMIT (Ea accident) D 1,000,000 AUTOMOBILE LIABILITY X ANY AUTO 4022871677 07/01/2020 07/01/2021 BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS BODILY INJURY (Per accident PROPERTY DAMAGE (Per accident) HIRED ONLY NON-OWNED AUTOS ONLY 2.000 Coll/Comp Ded 5,000,000 X ·UMBRELLA LIAB OCCUR **EACH OCCURRENCE** 4022871680 07/01/2020 07/01/2021 **EXCESS LIAB** Х CLAIMS-MADE 5.000,000 AGGREGATE 10.000 DED X RETENTIONS C WORKERS COMPENSATION AND EMPLOYERS' LIABILITY PER STATUTE ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) 07/01/2020 07/01/2021 TARNH1036127-00 1 000 000 E.L. EACH ACCIDENT 1,000,000 E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below 1,000,000 DISEASE - POLICY LIMIT 4022871663 07/01/2020 07/01/2021 EE Theft Crime 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** 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. For Information Only AUTHORIZED REPRESENTATIVE Norwood McElveen

DocuSign Envelope ID: 75BC859D-C032-4477-A486-ECA7B530F5CA

NOTEPAD

INSURED'S NAME Merrimac Medical Investors LLC

MERRI-1 OP ID: AL PAGE 2 Date 10/30/2020

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

12/17/2020

Date

Date -

Tien M. Movie

Name: ETSas M. Morris

Title: Director, Division of Public Health Srvcs.

METRO HEALTH FOUNDATION OF NEW HAMPSHIRE

-DocuSigned by:

Rosemany Simino

Name: Rosemary Simino

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 \$140,900.00, for the number of test listed in Section 4.
- 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.

Name



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 f					
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2) How many	staff members does your facility	/ have?	' 		
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Title RS Date 12/17/2020

State of New Hampshire **Department of State**

CERTIFICATE

1, 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

1, <u>Jeanne V. Sanders</u> , 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, DX. (Corporation/LLC Name) albia Golden View Health Care
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, 20, at which a quorum of the Directors/shareholders were present and voting. (Date)
VOTED: That tase mary Simina Administrator (may list more than one person) (Name and Title of Contract Signatory) Metro Hearth Foundation of
is duly authorized on behalf of New Ahmashue, Inc. to enter into contracts or agreements with the State (Name of Corporation/ LLC) dbla Golden View Hawth Care Center
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 imits 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 Same Janders
Signature of Elected Officer
Name: Jeanne Sanders Title: CEO/Director
(I-O)/Ducantin

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(les) 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). USI Insurance Services LLC PHONE (A/C, No, Ext): 855 874-0123 E-MAIL (A/C, No): 3 Executive Park Drive, Suite 300 ADDRESS: Bedford, NH 03110 INSURER(S) AFFORDING COVERAGE NAIC # 855 874-0123 INSURER A : Ironshore Specialty Insurance Co. 25445 INSURED INSURER B : Atlantic Charter Insurance Company 44326 Metro Health Foundation of NH d/b/a INSURER C : Continental Western Insurance Company 10804 Golden View Health Care Center INSURER D 19 NH Route 104 INSURER E Meredith, NH 03253 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. ADDL SUBR POLICY EFF (MM/DDYYYY) **POLICY NUMBER** COMMERCIAL GENERAL LIABILITY Δ X 003947001 01/04/2020 01/04/2021 **EACH OCCURRENCE** \$1,000,000 X CLAIMS-MADE DAMAGE TO RENTED PREMISES (Ea occurrence) OCCUR s100,000 MED EXP (Any one person) s10.000 PERSONAL & ADV INJURY \$1,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE \$3,000,000 X PRO-POLICY \$3,000,000 PRODUCTS - COMP/OP AGG OTHER: C AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT (Ea accident) CAA527827614 01/04/2020 01/04/2021 £1.000.000 ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED BODILY INJURY (Per accident) AUTOS NON-OWNED AUTOS ONLY PROPERTY DAMAGE (Per socident) HIRED AUTOS ONLY UMBRELLA LIAB Α OCCUR 003947101 01/04/2020 01/04/2021 EACH OCCURRENCE \$5,000,000 **EXCESS LIAB** X CLAIMS-MADE AGGREGATE \$5,000,000 DED X RETENTION \$\$0 WORKERS COMPENSATION AND EMPLOYERS' LIABILITY В WCA00569601 01/04/2020 01/04/2021 X STATUTE ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? 3A States: NH E.L. EACH ACCIDENT s1,000,000 Ν (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE \$1,000,000 If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT \$1,000,000 Professional 003947001 01/04/2020 01/04/2021 \$1,000,000 Ea. Incident Liability \$3,000,000 Aggregate 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 State of NH THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN Department of Health and Human Services ACCORDANCE WITH THE POLICY PROVISIONS. 129 Pleasant Street

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Concord, NH 03301

AUTHORIZED REPRESENTATIVE

San Hoof

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.

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- 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.

State of New Hampshire

Department of Health and Human Services

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

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

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.
- 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.

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) 688-2373	576	\$ 57,600,00
St. Vincent de Paul Rehabititation 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

1) Name of facility:



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

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

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2) Seaffeania	an lab artitionals				
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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 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; ca	annot be contract signatory)
I am a duly elected Clerk/Secretary/Officer of New Hampshi (Corporation/L)	ire Catholic Charities
2. The following is a true copy of a vote taken at a meeting of the held on <u>September 19</u> , 20 19, at which a quorum of the (Date)	e Board of Directors/shareholders, duly called and e Directors/shareholders were present and voting.
VOTED: That David Hildenbrand, Chief Financial Officer (Name and Title of Contract Signatory)	(may list more than one person)
is duly authorized on behalf of New Hampshire Catholic Charities (Name of Corporation/ LLC)	to enter into contracts or agreements with the State
of New Hampshire and any of its agencies or departments documents, agreements and other instruments, and any amerimay in his/her judgment be desirable or necessary to effect the	ndments, revisions, or modifications thereto, which
3. I hereby certify that said vote has not been amended or repedate of the contract/contract amendment to which this certificat thirty (30) days from the date of this Certificate of Authority. I for New Hampshire will rely on this certificate as evidence that position(s) indicated and that they have full authority to bind to limits on the authority of any listed individual to bind the corporate all such limitations are expressly stated herein. Dated: 1/04/21	ate is attached. This authority remains valid for urther certify that it is understood that the State of the person(s) listed above currently occupy the the corporation. To the extent that there are any



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).

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
11/20/2020

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

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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:
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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	June M. Morris
Date	Name objects the ris
	Title: Director, Division of Public Health Srvcs.
	NH ODD FELLOWS HOME
12/19/2020	anne funnton
Date	Name
	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

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- 2. The Department shall pay the Grantee a total amount of \$89,600.00, for the number of test listed in Section 4.
- 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.

Date



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

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

2) How man	y staff members does your facility	have?			
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4) Reimburs	ement type (please check all that a	pply):			
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12/19/2020

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 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 Corp	oration/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 <u>New Hampshire Odd Fellows home</u>, <u>Inc.</u> 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.

Signature of Elected Offider Name: Robert W. wright, or

Title: President



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(les) 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 CONTACT Rachel Giunta														
THE ROWLEY AGENCY INC.								JULI DE LA CONTRACTOR D						
45 Constitution Avenue								[AIC, No. Ext): (603) 224-2562 [AIC, No]: (603) 224-8012						
1								E-MAIL ADDRESS: rgiunta@rowleyagency.com						
P.O. Box 511 Concord NE 03302-0511							•				ROING COVERAGE		NAIC #	
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Rachel A Giventa

Rachel Giunta/RG

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

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.
- 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.

1) Name of facility:



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

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

	ng lab utilized;					
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State of New Hampshire Department of State

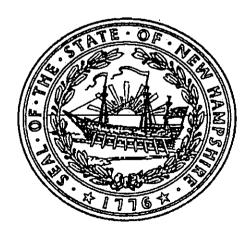
CERTIFICATE OF REGISTERED TRADE NAME OF ALPINE HEALTHCARE CENTER

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 1D: 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

State of New Hampshire Department of State

CERTIFICATE

1, 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)

Į,	sha Margulies, hereby certify that:
-	(Name of Sole Member/Manager of Limited Liability Company, Contract Signatory - Print Name)
1.	am the Sole Member/Manager of the Company of Avrohom Goldstein (Name of Limited Liability Company)
	(Name of Emilied Clabinty Company)
2.	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
	uthority.
	3rda M
	(Contract Signature)
	1/4/2021
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	On this the day of 20, before me (Name of Notary Public / Justice of the Peac
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	hat he/she executed the same for the purposes therein contained. In witness whereof, I hereunto set my har
	and official seal.
	(NOTARY SEAL)
	(Notary Public / Justice of the Peace -Signature)
	Commission Expires:

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CERTIFICATE OF LIABILITY INSURANCE

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).

<u> </u>	his certificate does not confer rights t	o the	Cert	ifficate holder in lieu of su	uch end	cy, certain p dorsement(s)	olicies may).	require an endorsement.	A St	atement on	
PRO	DOUCER		21:	2-687-4600	CONTACT NAME:						
Oni	ecap Services LLC Spruce Street				PHONE (AJC, No, Ext): 212-687-4600 [FAX (AJC, No): 516-612-6137						
Ced	darhurst, NY 11516				E-MAIL ADDRESS:						
							URER(S) AFFOR	DING COVERAGE		NAIC #	
_					INSURER A: TDC Specialty Underwriters						
JNS	uren ik Healthcare at Keene LLC				INSURE						
d/b/	a Alpne Healthcare Center				INSURE	RC:Redwo	od Fire & C	asualty Ins Co	T i		
Kee 298	ne SNF Realty LLC Main Street			1	INSURER D : Great American Ins Co					16691	
Kee	ene, NH 03431				INSURER E :						
					INSURER F:						
				E NUMBER;				REVISION NUMBER:			
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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR	POLICY NUMBER		POLICY EFF (MM/DD/YYYY)	POLICY EXP	LIMITS			
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	X CLAIMS-MADE OCCUR	x	.x	LTP-01238-20-00		11/19/2020	11/19/2021	DAMAGE TO RENTED PREMISES (Ea occurrence)		100,000	
	χ Prior Acts: 11/19		i					MED EXP (Any one person)		5,000	
	X Deductible \$100,0		ļ					PERSONAL & ADV INJURY	;	1,000,000	
	GENL AGGREGATE LIMIT APPLIES PER:							GENERAL AGGREGATE	<u> </u>	3,000,000	
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	ANY AUTO OWNED AUTOS ONLY X SCHEDULED AUTOS		X	73APB004068	0//14	07/14/2020	07/14/2021	BODILY INJURY (Per person) \$			
								BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$	<u> </u>		
	AUTOS ONLY NON-OWNED							(Per accident) \$	<u> </u>		
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	DED RETENTION\$							AGGREGATE			
С	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	 				<u> </u>	PER OTH-	•			
			х	WMWC114868		11/19/2020	11/19/2021	E.L. EACH ACCIDENT \$		1,000,000	
	(Mandatory in NH)	N/A						E.L. DISEASE - EA EMPLOYEE \$:	1,000,000	
	If yes, describe under DESCRIPTION OF OPERATIONS below							E.L. DISEASE - POLICY LIMIT S		1,000,000	
Α	Prof Liability			LRP-01238-20-00		11/19/2020	11/18/2021	Each Inci		1,000,000	
D	Crime			SAA E651971-00-00	j	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						CANCELLATION					
CE	RTIFICATE HOLDER				CANC	ELLATION					
Congressional Bank, a Maryland chartered commercial bank ISAOA						SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.					
	4445 Willard Avenue Suite 1000				AUTHORIZED REPRESENTATIVE						

ACORD 25 (2016/03)

Chevy Chase, MD 20815

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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.</p>
 - 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.

State of New Hampshire

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

Department of Health and Human Services

1/4/2021

Date

Decusioned by:
Name:
Name:
Title: Director, Division of Public Health Srvcs.

PEAK HEALTHCARE AT PORTSMOUTH LLC

1/4/2021

Date

1/4/2021

Date

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.
- 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.

Date 1/4/2021



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

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

1					
2) How mar	y staff members does your facility	have?			
3) Staff testi	ng lab utilized:				
4) Kelmburs	ement type (please check all that	apply):			
s	urveillance				
	utbreak/Response				
□ c	ounty rate greater than 5%				
c	ounty rate greater than 10%	·			
5) How man	y residents does your facility have	? (if outbreak/res	sponse is checked)		
6) Resident	esting lab utilized (if different fro	m staff and outbr	eak/response is checked	le:	
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	Week 1 Second Test Date	Total Staff		Rate \$100/Test	
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1/4/2021

State of New Hampshire Department of State

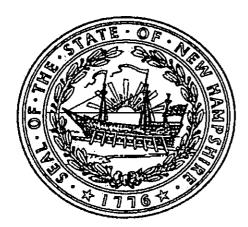
CERTIFICATE OF REGISTERED TRADE NAME OF CEDAR HEALTHCARE CENTER

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

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:
<i>'</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 ofAvrohom 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 hind. Peak Healthcare at Portsmouth LLC
	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.
	3 Ulas M
	(Contract Signatory - Signature)
	1/4/2021
	(Date)
	(Dire)
	STATE OF
	COUNTY OF
	On this the day of 20, before me
	On this the day of 20, before me (Name of Notary Public / Justice of the Peace) the undersigned officer, personally appeared, known to me (or
	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 Funits

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).

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	ODUCE ecap	R Services LLC		21	2-687-4600	CONTACT NAME: PHONE 212-687-4600 FAX 516.612.6127				
77 Spruce Street Cedarhurst, NY 11516			(A/C, No, Ext): 2 2 3 1 4 3 1							
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									IDING COVERAGE	NAIC#
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Pea	INSURED Peak Healthcare at Portsmouth LLC			INSURI		al Indemnit				
100	d/b/a Cedar Healthcare Center Portsmouth SNF Realty LLC 188 Jones Ave Portsmouth, NH 03801						asualty ins Co			
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	X	Prior Acts: 11/19							MED EXP (Any one person) \$	5,000
	X	Deductible \$100,0	1	1					PERSONAL & ADV INJURY \$	1,000,000
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	ANY I	PROPRIETOR/PARTNER/EXECUTIVE CER/MEMBER EXCLUDED?	NIA	X	WMWC114868		11/19/2020	11/19/2021	E.L. EACH ACCIDENT \$	1,000,000
		CER/MEMBER EXCLUDED?							E.L. DISEASE - EA EMPLOYEE \$	1,000,000
_		, describe under CRIPTION OF OPERATIONS below	!	_			`		E.L. DISEASE - POLICY LIMIT \$	1,000,000
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Loc As i incl Cer	ation requ udeo tifica	ion of operations / Locations / Vehici n: 188 Jones Ave, Portsmoutl ired by written contract and p d as Additional Insured. A wa ate holder will receive 30 days r nonpayment of premium.	h, Ni		801 v form. Certificate Hold	der ie	e attached if mor	e space la requir	ed)	
CEI	RTIF	ICATE HOLDER				CANO	ELLATION		<u></u>	
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	Congressional Bank, a Maryland chartered commercial bank ISAOA 4445 Willard Avenue				A	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.				
		Suite 1000					RIZED REPRESEI			
	Chevy Chase, MD 20815				I Po O Les					

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
- 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.</p>
 - 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.

State of New Hampshire

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

Department of Health and Human Services

1/4/2021

Date

Docusioned by:
Name
Name
Director, Division of Public Health Srvcs.

PEAK HEALTHCARE AT ROCHESTER LLC

Docusioned by:
Name
Name
Name
Name
Name
Name
Director, Division of Public Health Srvcs.

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 \$ 68,400.00, for the number of test listed in Section 4.
- 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.



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

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

	acility:					
2) How many	y staff members does your facility	have?				
2) 1100 111111	starr members does your taching	nave;			•	
3) Staff testin						
4) D-3-b					•	
4) Keimburse	ement type (please check all that a	ipply):				
☐ Su	rveillance					
Ou	utbreak/Response					-
Co	ounty rate greater than 5%					
Co	ounty rate greater than 10%					
5) How many	y residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	esting lab utilized (if different fro	m staff and outbre	eak/response is checked):		
·			•	•		
						
Month for reimbu	rsement period: Select M	lonth				
Week 1 Test Date	Week 1 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	
	(if applicable)	Tested	(if applicable)		Amount	
				\$100/Test		
Week 2 Test Date	Week 2 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	
	(if applicable)	Tested	(if applicable)		Amount	
				\$100/Test		
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Week 3 Test Date Week 4 Test Date				Rate		
	(if applicable) Week 4 Second Test Date	Tested Total Staff	(if applicable) Residents Tested	Rate \$100/Test	Amount Reimbursement	
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State of New Hampshire Department of State

CERTIFICATE OF REGISTERED TRADE NAME

OF

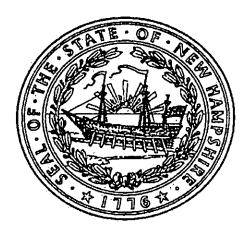
BIRCH HEALTHCARE CENTER

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

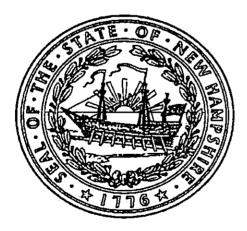
State of New Hampshire Department of State

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 Scal 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)

Ι,	Zisha Margulies	, hereby certify that:
	(Name of Sole Member/Manager of Limited Liability Compa	any, Contract Signatory - Print Name)
	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 Stat	•
	evidence that I have full authority to bind Peak He	ealthcare 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.	
	(Contract Signatory - Signature)	
	(Contract Signatory - Signature)	
	1/4/2021 (Date)	
	(Date)	
	STATE OF	
	COUNTY OF	
	On this the day of 20	, before me
	(Day) (Month) (Y	(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 Evnings	

OP ID: BB



CERTIFICATE OF LIABILITY INSURANCE

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). 212-687-4600 PRODUCER
Onecap Services LLC FAX (A/C. No): 516-612-6137 PHONE (A/C, No, Ext): 212-687-4600 77 Spruce Street Cedarhurst, NY 11516 ADDRESS: INSURER(S) AFFORDING COVERAGE NAIC # INSURER A: TDC Specialty Underwriters INSURED
Peak Healthcare at Rochester LLC
d/b/a Birch Healthcare Center
Rochester SNF Realty LLC
62 Rochester Hill Rd INSURER B : National Indemnity Co. .Redwood Fire & Casualty Ins Co INSURER C INSURER D Great American Ins Co 16691 Rochester, NH 03867 INSURER E INSURER F : **COVERAGES** <u>CERTIFICATE NUMBER</u> 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 ADDL SUBR POLICY EFF POLICY EXP TYPE OF INSURANCE **POLICY NUMBER** LIMITS X COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE
DAMAGE TO RENTED
PREMISES (Ea occurrence) X CLAIMS-MADE OCCUR 100,000 11/19/2020 11/19/2021 LTP-01238-20-00 X Prior Acts: 11/19 5,000 MED EXP (Any one person) Deductible \$100.0 Χ 1,000,000 PERSONAL & ADV INJURY 3,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE 1328 X Loc POLICY 1,000,000 PRODUCTS - COMPIOP AGG COMBINED SINGLE LIMIT (Ea accident) В AUTOMOBILE LIABILITY 1,000,000 ANY AUTO 73APB004068 Х 07/14/2020 07/14/2021 BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS BODILY INJURY (Per accident) HIRED ONLY PROPERTY DAMAGE (Per accident) NONSYNED UMBRELLA LIAB **OCCUR EACH OCCURRENCE EXCESS LIAB** CLAIMS-MADE **AGGREGATE** DED RETENTION \$ C WORKERS COMPENSATION AND EMPLOYERS' LIABILITY PER STATUTE 11/19/2020 11/19/2021 WMWC114868 ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Х 1,000,000 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 **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 / YEHICLES (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 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. Congressional Bank, a Maryland chartered commercial bank ISAOA 4445 Willard Avenue AUTHORIZED REPRESENTATIVE **Suite 1000** Chevy Chase, MD 20815

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.

State of New Hampshire

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

Department of Health and Human Services

1/5/2021

Date

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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

- 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.
- 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.



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

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

I) Name of f	acility:				
2) How many	staff members does your facility	y have?			
3) Staff testin	ng lab utilized:				
4) Reimburse	ement type (please check all that a	apply):			
☐ Su	rveillance				
	ntbreak/Response			•	
_					
_	ounty rate greater than 5%				
Co	ounty rate greater than 10%				
5) How many	residents does your facility have	:? (if outbreak/res	ponse is checked)		
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me		L Title		—	— ps Date

1/5/2021

State of New Hampshire Department of State

CERTIFICATE

1, 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

η_{1} 12
I, Mile Surger, 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 Val Street Hallhar UC (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
voted: That Wash Haministry (may list more than one person) (Name and Title of Contract Signatory) is duly authorized on behalf of Wash Street Hallow to enter into contracts or agreements with the State
is duly authorized on behalf of
of New Hampshire and any of its agencies or departments and further is authorized to execute any and a documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, whic 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.
Signature of Elected Officer Name: #11. sop E. Burin Title: Many

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	COMMERCIAL GENERAL LIABILITY	PP 020	01/01/2021	01/01/2022	FIRE DAMAGE (Any one fire)	50,000.	
Α	CLAIMS MADE OCCUR		01/01/2021		MED ENP (Any one person)	Excluded	
	Professional Liability				PERSONAL & ADV INJURY	Included	
	Premises Liability		,		GENERAL AGGREGATE	3,000,000.	
	GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	N/A	
	POLICY PRO- LOC LOC				NO Deductible Applie		
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Each action)		
	ALL OWNED AUTOS SCHEDULED AUTOS	·			BODILY INJURY (Fer person)		
	HIRED AUTOS				BODILY (NRURY (Per acrident)		
	NON OWNED AUTOS S1000 Ded. Collision				PROPERTY DAMAGE (Per accident)		
	S250 Ded Comp GARAGE LIABILITY			!	AUTO ONLY - EACH ACCIDENT		
	ANY AUTO				OTHER THAN EA ACC AUTO ONLY:		
_	ENCESS LIABILITY			,	AGG EACH OCCURRENCE		
	OCCUR CLAIMS MADE				AGGREGATE		
	DEDUCTIBLE						
	RETENTION \$ 0						
	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY	10804014-16	01/01/2021	01/01/2022	TORY LIMITS EX		
Α		10004014-10	01/01/2021	01/01/2022	E.L. EACH ACCIDENT	1,000,000	
					E.L. DISEASE-POLICY LIMIT	1,000,000	
_	OTHER	<u> </u>			E.L. DISEASE-EA EMPLOYEE	1,000,000	
DESC	RIPTION OF OPERATIONS/LOCATIONS/YEHR	CLESTEXCLUSIONS ADDED BY ENDORSE	MENTISPECIAL PROVISION	NS	<u> </u>		
E,	vidence of Insurance - Pear	i Street HealthCare Cen	ter, LLC d/b/a l	Maple Leaf H	ealthCare Center		
ĊEſ	RTIFICATE HOLDER	了对某种国际工程工程的	CANCELLATIO	00.189.生产		The second second	
Department of Health and Human Services 129 Pleasant Street Concord, NH 03301			SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEROY, 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				
A C C	RD/25/S (7/97) 医心脑中心部		Carry Warrency	Paul M	racey	CONTRACTOR THE PARTY	
Certificate No			本語の第一次に対象的では、1年でACORDICORRORATION(1988]には 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

12/31/2020	Trea M. Morris
Date	Name: Lisa M. Morris
	Title: Director, Division of Public Health Srvcs.
	PETERBOROUGH RETIREMENT COMMUNITY AT UPLAND FARM INC
12/30/2020	Docusigned by: Drime Contey
Date	Name: Salme 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.
- 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.



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 fa	icility:					
2) How many	staff members does your facility	have?				
3) Staff testin	e lab utilized					
4) Reimburse	ment type (please check all that a	pply):				
Su	rveillance					
Ou	tbreak/Response					^
— П с	unty rate greater than 5%					
_	•					
C₀	unty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	esting lab utilized (if different from	n staff and outbre	ak/response is checked)			
lonth for reimbu	rsement period: Select M	onth				
	Week 1 Second Test Date	Total Staff	Residents Tested		Reimbursement	
Week 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount	
				\$100/Test		
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
	(ii application)	Tested	(ii applicable)	\$100/Test		
Week 3 Test Date	Week 3 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	
Meek 2 Lest Date	(if applicable)	Tested	(if applicable)		Amount	
	Week 4 Second Test Date	Total Staff	Residents Tested	\$100/Test	Reimbursement .	
Week 4 Test Date	(if applicable)	Tested	(if applicable)	Rate	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	
(п аррпсарте)	(п аррисаоле)	Tested	(п аррисавле)	\$100/Test	Amount	
			<u> </u>	, ., .		
						
ame		Title			Oc Date	
		71115		- {	12/3	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 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

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. 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

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).

	is certificate does not confer rights	o the	cert	ificate holder in lieu of st			<u>'•</u>			
	DUCER nson, Kendall & Johnson, Inc.				CONTACT NAME: PHONE (AIC, No, Ext): (215) 968-4741 FAX (AIC, No, Ext): (215) 968-0973					
	Pheasant Run				(A/C, No	o, Ext); (213) :	968-4741		(A/C, No); (21	5) 968-0973
Vev	rtown, PA 18940				ADORE	_{ss:} info@jkj	.com			
						IN:	SURER(S) AFFOR	IDING COVERAGE		NAIC #
					INSURE	RA: AIX Sp	<u>ecialty Insu</u>	<u>rance Compa</u>	<u>ny</u>	12833
INSL	RED				INSURE	R 8 : Allmeri	<u>ca Financia</u>	<u>I Benefit Insu</u>	rance	41840
	Peterborough Retirement C	omm	unity	at Upland Farm, Inc.	INSURE	RC: MEMIC	Indemnity :	Company		11030
	150 RiverMead Road				INSURE	RD: Massac	husetts Ba	y Insurance C	ompany	22306
	Peterborough, NH 03458				INSURE	RE:				
					INSURE	RF:				
co	VERAGES CE	RTIFIC	CATE	NUMBER:				REVISION NU	MBER:	
C	HIS IS TO CERTIFY THAT THE POLICI IDICATED. NOTWITHSTANDING ANY I ERTIFICATE MAY BE ISSUED OR MAY XCLUSIONS AND CONDITIONS OF SUCH	REQUI	IREMI TAIN,	ENT, TERM OR CONDITION THE INSURANCE AFFOR	N OF A	NY CONTRA	CT OR OTHER IES DESCRIB	DOCUMENT WI	TH RESPECT	TO WHICH THIS
NSR	TYPE OF INSURANCE		SUBR WVD			POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)		LIMITS	•
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	X CLAIMS-MADE OCCUR	1		L1Y-D460734-02		1/1/2020	1/1/2021	DAMAGE TO RENT PREMISES (Ea occ	ED .	100,000
		1						MED EXP (Any one		5,000
								-		1,000,000
				1				PERSONAL & ADV		3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO- JECT LOC							GENERAL AGGREG	1	3,000,000
								PRODUCTS - COM	P/OP AGG \$	-,,-
В	OTHER:	┼	╁					COMBINED SINGLE	ELIMIT .	1,000,000
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	OWNED SCHEDULED AUTOS ONLY			AVV 1-D460756-02		1/1/2020	1/1/2021	BODILY INJURY (P		
		-		i				PROPERTY DAMAG (Per accident)		
	HIRED ONLY AUTOS ONLY							(Per accident)	\$	
Α	 	┼	 			<u> </u>			- \$	6,000,000
^	UMBRELLA LIAB OCCUR	.l	1	L1Y-D460735-02		1/1/2020	1/1/2021	EACH OCCURREN	CE \$	6,000,000
	X EXCESS LIAB X CLAIMS-MADE	4	[211-5400755-02		17172020	1,1,2021	AGGREGATE	\$	
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C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			3102802040		1/1/2020	1/1/2021	X PER STATUTE	<u>LĚR</u>	500,000
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A		3102802040		17172020	17172021	E.L. EACH ACCIDE	NT \$	
	(Mandatory in NH) If yes, describe under	-						E.L. DISEASE - EA	EMPLOYEE \$	500,000
_	DESCRIPTION OF OPERATIONS below	<u> </u>	<u> </u>	DDV D 400740 00		4/4/0000	41410004	E.L. DISEASE - POI		500,000
D	Property		•	RDY-D460740-02		1/1/2020	l i	Blanket Bldg &	& BPP	72,341,633
D	Property			RDY-D460740-02		1/1/2020	1/1/2021	Deductible		50,000
DE\$	 CRIPTION OF OPERATIONS / LOCATIONS / VEHIC	LES (A	I AACORE	 101, Additional Remarks Schedu	ile, may b	e attached if mor	re space is requir	ed}		
	RTIFICATE HOLDER			- ····	CANC	ELLATION				
<u>- L</u>	THE HOLDEN				70,10	ELECTION.				
	DHHS 129 Pleasant St Concord, NH 03301				THE	EXPIRATION	N DATE TH			CELLED BEFORE DELIVERED IN
	Concord, NA 03301				AUTHO	RIZED REPRESE	NTATIVE			

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.</p>
 - 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	Docysigned by: That M. Movine					
Date	Name. Morris					
	Title: Director, Division of Public Health Srvcs.					
	RANNIE WEBSTER FOUNDATION					
12/21/2020	Docusigned by: Tom draw					
Date	Namesosodia rangue					
	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.
- 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.

Date 12/21/2020



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 fa	eility:	,			
2) How many	staff members does your facility	have?			
3) Staff testin	g lab utilized:				
4) Reimburse	ment type (please check all that a	pply):			
Su	rveillance				
_ o _u	tbreak/Response				
_ □ c₀	unty rate greater than 5%				
	unty rate greater than 10%				•
	residents does your facility have	? (if outbreak/res)	nonse is checked)		
	esting lab utilized (if different from			۸.	
6) Resident to	isting tab utilized (it different from	m statt and outbro	eak/response is enecked):	
nth for reimbu	rsement period: Select M	onth			
	Week 1 Second Test Date	Total Staff	Residents Tested	n-t-	Reimbursement
eek 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount
				\$100/Test	
eek 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff <u>Tes</u> ted	Residents Tested (if applicable)	Rate	Reimbursement Amount
				\$100/Test	
eek 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
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eek 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
			,	\$100/Test	
eek 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount
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12/21/2020

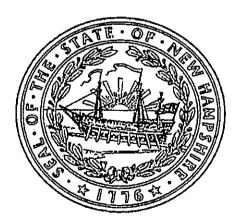
State of New Hampshire Department of State

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 Scal 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(les) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, aubject 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). CONTACT S
NAME:
PHONE
(A/C, No. Ext):
E-MAIL PRODUCER Scott Wellington Cross Insurance-Portsmouth (603) 812-2600 FAX (A/C, No): (603) 570-1073 75 Portsmouth Blvd. swellington@crossagency.com ADDRESS Suite 100 INSURER(S) AFFORDING COVERAGE NAIC # **Portsmouth** NH 03801 American Alternative Ins Corp INSURER A : INSURED Granite State Health Care and Human Services Self-INSURER B : Rannie Webster Foundation, DBA: Webster at Rye INSURER C 795 Washington Road INSURER D : INSURER E : Rye NH 03870 WSURER F: **COVERAGES** CL2041320092 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. ADDLISUBR TYPE OF INSURANCE POLICY NUMBER COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) CLAMS-MADE L 1,000,000 15,000 MED EXP (Any one person) SLA3-NL-6150187-00 04/01/2020 04/01/2021 1,000,000 PERSONAL & ADV INJURY GEN'LAGGREG<u>ate</u> LIMIT APP<u>LIES</u> PER: 3,000,000 **GENERAL AGGREGATE** POLICY 3,000,000 PRODUCTS - COMP/OP AGG s OTHER: Employee Benefits s 1,000,000 AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT (Ea accident) s 1,000,000 ANY AUTO BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED SLHH-HA-1050949-00 04/01/2020 04/01/2021 BODILY INJURY (Per accident) AUTOS NON-OWNED AUTOS ONLY HIRED AUTOS ONLY PROPERTY DAMAGE Underinsured motorist BI s 1,000,000 UMBRELLA LIAB OCCUR 1.000.000 EACH OCCURRENCE EXCESS LIAB SLA3-NE-3150128-00 04/01/2020 CLAIMS-MADE 04/01/2021 1,000,000 AGGREGATE DED X RETENTION \$ 10,000 WORKERS COMPENSATION X PER TUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) 1.000.000 Ν E.L. EACH ACCIDENT HCHS20200000229 02/01/2020 02/01/2021 1,000,000 E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below 1,000,000 E.L. DISEASE - POLICY LIMIT General Aggregate 3 000 000 Professional Liability SLG4-NL-8000018-00 04/01/2020 04/01/2021 Each Occurrence 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 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. State of New Hampshire AUTHORIZED REPRESENTATIVE

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.</p>
 - 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.

State of New Hampshire

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

Department of Health and Human Services 01/04/2021 Name: Lisa Morris Title: Director **ROCKINGHAM COUNTY**

Title:

ROCKINGHAM COUNTY SS-2021-DPHS-11-LONGT-48-A01

Date

Date

12/23/2020



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.
- 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 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 man	y staff members does your facility	v have?				
3) Staff testin	ng lab utilized:		1			
4) Reimburs	ement type (please check all that a	apply):				
∏ sı	rveillance		•			
_ 	atbreak/Response					
_						
☐ C	ounty rate greater than 5%					
c	ounty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	esting lab utilized (if different fro	m staff and outbr	eak/response is checked):	. •	
			,			
•						
Month for reimbu	rsement period: Select M	lonth				
Wash 1 Task Date	Week 1 Second Test Date	Total Staff	Residents Tested	<u> </u>	Reimbursement	
Week 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	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	Rate	Reimbursement	
· · · · · · · · · · · · · · · · · · ·	in applicable)	153160	(if applicable)	\$100/Test	Amount	
Week 5 Test Date	Week 5 Second Test Date	Total Staff .	Residents Tested	Rate	Reimbursement	
(if applicable)	(if applicable)	Tested	(if applicable)	╌╌┢	Amount	
				\$100/Test		
-	Chair		-			

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 (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: M	fember Number:		Company Affording Coverage:				
Rockingham County 119 North Road Brentwood, NH 03833	609		NH Public Risk Management Exchange - Prime Bow Brook Place 46 Donovan Street Concord, NH 03301-2624				
Type of Coverage	Effective Date (mm/dd/yyyy)	Expiration L (mm/dd/yy		Limits - NH Statutory Limits	May Apply, If Not:		
X General Liability (Occurrence Form)	1/1/2020	1/1/202		Each Occurrence	\$ 5,000,000		
Professional Liability (describe)	"			General Aggregate	\$ 5,000,000		
Claims Occurrence				Fire Damage (Any one fire)			
				Med Exp (Any one person)			
X Automobile Liability Deductible Comp and Coll: \$1,000	1/1/2020	1/1/202	:1	Combined Single Limit (Each Accident)	\$ 5,000,000		
Any auto		l	I	Aggregate	\$ 5,000,000		
Workers' Compensation & Employers' Liability		-		Statutory			
			ļ	Each Accident			
•				Disease — Each Employee			
			!	Disease - Policy Limit			
X Property (Special Risk includes Fire and Theft)	1/1/2020	1/1/202	:1	Blanket Limit, Replacement Cost (unless otherwise stated)	Deductible: \$1,000		
Description: Proof of Primex Member coverage only.							
CERTIFICATE HOLDER: Additional Covered Part	ty Loss P	avee	Prime	ex ³ – NH Public Risk Manager	ment Exchange		
	<u> </u>		By:	Mary Esth Purcell	men energe		
State of New Hampshire		l	Date:	12/2/2020 mpurcell@nhp	primex.org		
Department of Health and Human Services 129 Pleasant Street Concord, NH 03301				Please direct inquire Primex³ Claims/Coverage 603-225-2841 pho	je Services one		

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.

Page 1 of 2

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

Date

IER M. Morris

LTST M. Morris Name:

Title:

Director, Division of Public Health Srvcs.

SALEMHAVEN INC

12/30/2020

Date

Raymond Milliard

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 \$109,100.00, for the number of test listed in Section 4.
- 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.

Name



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

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

2) How man	y staff members does your facility	have?			•
3) Staff testin	ng lab utilized:				
4) Reimburse	ement type (please check all that a	1pply):			
☐ s₁	rveillance				
_					
	utbreak/Response	•			
Co	ounty rate greater than 5%				
Co	ounty rate greater than 10%			•	
5) How many	residents does your facility have	? (if outbreak/res	sponse is checked)		
6) Resident to	esting lab utilized (if different fro	m staff and outbr	eak/response is checked):	
			l '	•	
					
<u></u>					
<u></u>					
for reimbu	rsement period: Select M	lonth			
n for reimbu	rsement period: Select M	lonth			
	Week 1 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement Amount
			Residents Tested (if applicable)	Rate \$100/Test	Reimbursement Amount
1 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date	Total Staff Tested Total Staff	(if applicable) Residents Tested	<u> </u>	Amount Reimbursement
1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	(if applicable)	\$100/Test	Amount
1 Test Date 2 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date	Total Staff Tested Total Staff Tested Total Staff	(if applicable) Residents Tested (if applicable) Residents Tested	\$100/Test	Reimbursement Amount Reimbursement
1 Test Date 2 Test Date 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate	Amount Reimbursement Amount
1 Test Date 2 Test Date 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement
1 Test Date 2 Test Date 3 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount
1 Test Date 2 Test Date 3 Test Date 4 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date (if applicable)	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate \$100/Test	Reimbursement Amount Reimbursement Amount Reimbursement Amount
1 Test Date 2 Test Date	Week 1 Second Test Date (if applicable) Week 2 Second Test Date (if applicable) Week 3 Second Test Date (if applicable) Week 4 Second Test Date	Total Staff Tested Total Staff Tested Total Staff Tested Total Staff Tested	(if applicable) Residents Tested (if applicable) Residents Tested (if applicable) Residents Tested (if applicable)	\$100/Test Rate \$100/Test Rate \$100/Test Rate	Reimbursement Amount Reimbursement Amount Reimbursement

RM

12/30/2020

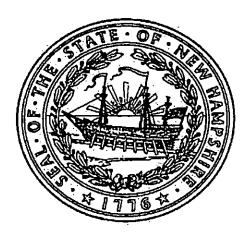
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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

CERTIFICATE OF AUTHORITY

- I; Greg Brown, hereby certify that:
- 1. Fam 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 10ecomba 83, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: That Ray Milliard and Brendan Siein

are duly authorized on behalf of <u>Salemhaven, Inc</u> 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: 12/23/202

Signature of Elected Officer

Name: Gregory

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 conditions not confirm the policy of such condenses and conditions of the policy.

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	. Box 69								
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ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/00/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). NAME: SANTO INSURANCE AND . PHONE (A/C, No. Ext): 224 MAIN ST STE 2A (A/C, No): ADDRESS: SALEM NH 030793192 INSURER(S) AFFORDING COVERAGE NAIC # 75TXL INSURER A: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA INSURED INSURER B SALEMHAVEN, INC. DBA INSURER C: SALEMHAVEN NURSING HOME; INSURER D: 23 GEREMONTY DR SALEM NH 03079-3314 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 ADDL SUBR POLICY EFF POLICY EXP TYPE OF INSURANCE INSD | WVD POLICY NUMBER LIMITS COMMERCIAL GENERAL LIABILITY **EACH OCCURRENCE** CLAIMS-MADE **OCCUR** PREMISES (En occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERA AGG BEGATE PROJECT PRODU<mark>ČTS – COMP/OP AGG</mark> AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) ANY AUTO OWNED AUTOS BODILY INJURY (Per accident) PROPERTY DAMAGE SCHEDULED AUTOS NON-OWNED AUTOS ONLY HIRED AUTOS (Per accident) UMBRELLA LIAB OCCUR EACH OCCURRENCE **EXCESS LIAB** CLAIMS-MADE AGGREGATE DED RETENTION WORKERS COMPENSATION (6JUB-4N98326-3-20) AND EMPLOYERS' LIABILITY STATUTE ER 06-22-20 06-22-21 ANY PROPRIETOR/PARTNER/EXECUTIVE 1,000,000 **EACH ACCIDENT** OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) N/A N 1,000,000 LLDISEASE - EA EMPLOYEE If yes, describe under DISEASE - POLICY LIMIT DÉSCRIPTION OF OPERATIONS belov 1,000,000

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

3A:NH;

CE	RT	IFIC	ATF	HOL	DER

CANCELLATION

STATE OF NH

CONCORD

129 PLEASANT ST

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 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.</p>
 - 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

Date

Name: Lisa M. Morris

VP

Title: Director, Division of Public Health Srvcs.

SCHOOL STREET ASSOCIATES INC

12/30/2020 Andrew Inviv

Name: Andrew Irwin

Title:

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 \$ 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.



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 fa	neility:					
2) How many	staff members does your facility	have?				
3) Staff testin	g lab utilized;		•			
4) Keimburse	ment type (please check all that a	pply):				
Su	rveillance					
Ou	tbreak/Response					
Пс	unty rate greater than 5%					
_	unty rate greater than 10%				•	
_						
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident te	esting lab utilized (if different from	n staff and outbro	eak/response is checked):		
<u> </u>						
						,
Month for reimbui	rsement period: Select M	onth				•
Week 1 Test Date	Week 1 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement]
	(if applicable)	Tested	(if applicable)	\$100/Test	Amount	1
	Week 2 Second Test Date	Total Staff	Residents Tested		Reimbursement	4
Week 2 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount	1
				\$100/Test		ļ
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Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
	((n applicable)	\$100/Test		Ī
Week 5 Test Date	Week 5 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	1
(if applicable)	(if applicable)	Tested	(if applicable)		Amount	1
				\$100/Test	<u> </u>	J
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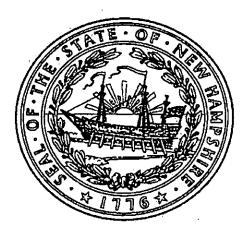
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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 confacts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated:12/28/20

Signature of Elected Officer

Máme: David Irwin Title: President/Officer

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). CONTACT Anna Gallant, ACSR, CISR, CRIS People's United Insurance Agency, Inc. PHONE (A/C, No, Ext): (603) 399-6148 FAX (A/C, No):(603) 399-6148 One Financial Plaza ADDRESS: Anna.Gallant@AssuredPartners.com Hartford, CT 06103 INSURER(S) AFFORDING COVERAGE NAIC # INSURER A : Ironshore Specialty Insurance Company 25445 INSURED INSURER B : Atlantic Charter Insurance Co 44326 School Street Associates Inc. d/b/a INSURER C : Great American Assurance Co 26344 Hillsboro House Nursing Home INSURER O **PO Box 400** Hillsboro, NH 03244 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. POLICY EFF POLICY EXP ADDL SUBR TYPE OF INSURANCE POLICY NUMBER LIMITS X COMMERCIAL GENERAL LIABILITY 1.000.000 EACH OCCURRENCE
DAMAGE TO RENTED
PREMISES (Ea occurrence) CLAIMS-MADE X OCCUR 002559104 100,000 11/8/2020 11/8/2021 Owner's & Contractor X 10.000 MED EXP (Any one person) Х Professional Liabili included PERSONAL & ADV INJURY 3,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE PRO-JECT Included POLICY LOC PRODUCTS - COMP/OP AGG OTHER: COMBINED SINGLE LIMIT (Ea accident) AUTOMOBILE LIABILITY ANY AUTO BODILY INJURY (Per person) SCHEDULED AUTOS OWNED AUTOS ONLY **BODILY INJURY (Per accident)** PROPERTY DAMAGE (Per accident) HIRED ONLY **MANASAULE** UMBRELLA LIAB **OCCUR** EACH OCCURRENCE **EXCESS LIAB** CLAIMS-MADE AGGREGATE DED RETENTION \$ WORKERS COMPENSATION AND EMPLOYERS' LIABILITY X PER STATUTE WCA00528509 11/8/2020 11/8/2021 500,000 ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) E.L. EACH ACCIDENT N/A 500,000 E.L. DISEASE - EA EMPLOYEE \$ yes, describe under DESCRIPTION OF OPERATIONS below 500.000 E.L. DISEASE - POLICY LIMIT 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 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. **Bureau of Contracts & Procurements** Department of Health and Human Services 129 Pleasant Street AUTHORIZED REPRESENTATIVE Concord, NH 03301 People's United Insurance Agency, Inc.

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	Jen M. Morris
Date	Name 3 BEF E CAMAO MOTTIS
	Title: Director, Division of Public Health Srvcs.
	Silverstone by Hunt
12/28/2020	Bran Newman
Date	Namez Bibara 2 lewman
•	Title: cco

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

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.
- 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.

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	Z	03452	448	\$ 44,800,00
SS-2021-DPHS-11-LONGT-13	The Huntington at Nashua	336260	55 Kent Ln,	Nashua	ИН	03062	482	\$ 48,200.00
· · · · · · · · · · · · · · · · · · ·								\$ 93,000.00

1) Name of facility:



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

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

2) How many	staff members does your facility	have?				
3) Staff testin	o lab utilized:					
3) Start testin	g lab ullitzed.					
4) Reimburse	ment type (please check all that a	pply):				
Su	rveillance		`			
Ou	tbreak/Response					
Co	unty rate greater than 5%					
☐ c₀	unty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	sting lab utilized (if different from	m staff and outbro	eak/response is checked):		
			,			
			·			
				•		
lonth for reimbu	rsement period: Select M	onth				
Week 1 Test Date	Week 1 Second Test Date (if applicable)	Total Staff Tested	Residents Tested	Rate	Reimbursement	
	(ii applicable)	resteu	(if applicable)	\$100/Test	Amount	7
	Week 2 Second Test Date	Total Staff	Residents Tested		Reimbursement	4
Week 2 Test Date	(if applicable)	Tested	(if applicable)	Rate	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		
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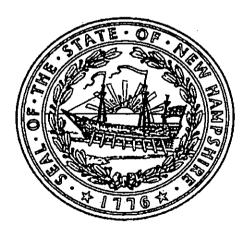
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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 1D: 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 <u>5i/verstone by Hunt</u> (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
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 a 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: Margaret Jaeb Title: Treasurer
Name: Margaret Jaeb Tille: Treasurer

ACORD

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). CONTACT NAME: Jenne Norton Fred C. Church Insurance PHONE (A/C, No, Ext); 978-458-1865 FAX (A/C, No): 978-454-1865 41 Wellman Street Lowell MA 01851 ADDRESS: inorton@fredcchurch.com

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INSU				SILVBYH-01	INSURER	в : A.I.M. М	utual Insuran	ce Co		33758
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	X CLAIMS-MADE OCCUR							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 100,00	00
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								MED EXP (Any one person)		
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	OTHER:)	\$	
C	AUTOMOBILE LIABILITY			6022608300 -		11/1/2020	11/1/2021	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,	000
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	OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					ŀ			
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	DESCRIPTION OF OPERATIONS below	<u> </u> 		<u> </u>					\$ 1,000,0	
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	SilverStone by Hunt			L						
	10 Allds Street			Į.	ALITHOPIZ	ED REPRESEN	TATIVE			

CERTIFICATE HOLDER	CANCELLATION
SilverStone by Hunt 10 Allds Street	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
Nashua NH 03060	AUTHORIZED REPRESENTATIVE

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
- 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.</p>
 - 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

ISA M. Movis 1/12/2021

Name: Lisa M. Morris

Title: Director, Division of Public Health Srvcs.

ST JOSEPH RESIDENCE INC

DocuSigned by: Marlene J. Makowski

Name: Mar Tene J. Makowski

Title: Administrator

12/18/2020

Date

Date

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 \$ 43,800.00, for the number of test listed in Section 4.
- 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.



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

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

I) Name of fa	acility:					
2) How many	staff members does your facility	have?		•		
3) Staff testir	ng lab utilized:].				
	· · · · · · · · · · · · · · · · · · ·					
4) Reimburse	ement type (please check all that a	ipply):				
Su	rveillance					
· 0.	utbreak/Response					
	tu sata assatus them 50/			•		
	ounty rate greater than 5%					
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5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
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	Week 2 Second Test Date	Total Staff	Residents Tested	\$100/Test	Reimbursement	
Week 2 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount	
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Week 3 Test Date	Week 3 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	
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	Week 4 Second Test Date	Total Staff	Residents Tested		Reimbursement	
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Week 5 Test Date (if applicable)	Week 5 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
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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 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 1D: 304367

Certificate Number: 0005032455



IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Scal of the State of New Hampshire, this 23rd day of October A.D. 2020.

William M. Gardner

Sccretary of State

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
VOTED: That Marlene J. Makowski NHA (may list more than one person) (Name and Title of Contract Signatory)
is duly authorized on behalf of <u>Sr. Mavie Henault</u> 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 Signature of Elected Officer Name: Sr. Marie Hernule, pm Title: Counsilm

				FICATE OF LIA					(MM/DD/YYYY)
	THIS CERTIFICATE IS ISSUED AS A CERTIFICATE DOES NOT AFFIRMA	MA	TER	OF INFORMATION ONL	Y AND CONFERS	NO RIGHTS	LIPON THE CERTIFIC	·	/21/2020
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CERTIFICATE HOLDER CANCELLATION 30

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

W. 111601

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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).

tl	ils certificate does not confer any rig	hts to	tho				nt(s).			1
	DUCER				CONTACT NAME:					
	I Insurance Services LLC				PHONE (A/C. No	_{i, Ext);} 855 87	4-0123	FAX (A/C, No):		
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	AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE Y / N OFFICER/MEMBER EXCLUDED?			3A States: NH					s1,000	0.000
	(Mandatory in NH)	N/A						E.L. DISEASE - EA EMPLOYEE		
	If yes, describe under DESCRIPTION OF OPERATIONS below						Ì	E.L. DISEASE - POLICY LIMIT		
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oes Ins	CRIPTION OF OPERATIONS / LOCATIONS / VEHIN Ured: St. Joseph Residence	CLES (A	CORD) 101, Additional Remarka Schedu	le, may l	e attached If mo	re space la requi	lred)		
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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.</p>
 - 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

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 \$284,600.00, for the number of test listed in Section 4.
- 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
1	i :

- 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.

12/30/202

1) Name of facility:



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

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

2) How man	y staff members does your facility	have?				
3) Staff testi	ng lab utilized:					
4) Reimburs	ement type (please check all that a	inula).				
_		·PP' 7 7·				
S	urveillance	•				
□ ∘	utbreak/Response					
Пс	ounty rate greater than 5%					
_			•			
	ounty rate greater than 10%					
5) How man	y residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident (esting lab utilized (if different fro	m staff and outbro	eak/response is checked):		
Month for reimbu	rsement period: Select M	lonth				
····	Week 1 Second Test Date	Total Staff	Residents Tested		Reimbursement	\neg
Week 1 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount	
			-	\$100/Test		
Week 2 Test Date	Week 2 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement	1 .
	(п аррисавте)	rested	(п аррпсавле)	\$100/Test	Amount	=
Week 3 Test Date	Week 3 Second Test Date	Total Staff	Residents Tested	-	Reimbursement	-
week 3 Test Date	(if applicable)	Tested	(if applicable)	Rate	Amount	<u>-</u>
				\$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	Week 5 Second Test Date	Total Staff	Residents Tested	Rate	Reimbursement	-
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Name		Tial -			—os	-
Name		Title			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 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.

Notary Public

Commission Expiration Date: ノメルター



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, Primox³ 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 after the coverage afforded by the coverage categories listed below.

Participating Member:	Me	mber Number:	- T	Compan	y Affording Coverage:	
Strafford County 259 County Farm Road Dover, NH 03820		605		Bow Bi 46 Don Concor	blic Risk Management Ex rook Place lovan Street d, NH 03301-2624	_
Type of		Effective Date T	Expiration D	ote V	Limits: NH Statutory Limits	May Apply, If Not +
X General Liability (Oc Professional Liabilit Claims Made		1/1/2020	1/1/202	1 [] (Each Occurrence General Aggregate Fire Damage (Any one ire) Med Exp (Any one person)	\$ 5,000,000 \$ 5,000,000
Automobile Liability Deductible Comp a	and Coll:		-	(Combined Single Limit Each Accident) Aggregate	
X Workers' Compensa	tion & Employers' Liability	1/1/2020	1/1/2021	1 ,	Statutory	\$2,000,000
				•	Each Accident	\$2,000,000
					Disease — Each Employee	
					Disease - Policy Limit	
Property (Special Risk	(includes Fire and Theft)				tlanket Limit, Replacement lost (unless otherwise stated)	
Description: Proof of Prime	ex Member coverage only.					
CERTIFICATE HOLDER:	Additional Covered Party	Loss P	ayee 1	Primex ³	– NH Public Risk Manage	ment Exchange
	· · · · · · · · · · · · · · · · · · ·	. .		By:	Mary Ech Purcell	
State of New Hampshire		······································		Date:	10/27/2020 mpurcell@n	harimay ara
Department of Health and H 129 Pleasant Street Concord, NH 03301	luman Services		-	- 414.	Please direct Inquire Primex³ Claims/Coverage 603-225-2841 pho 603-228-3833 fa	es lo: o Services one



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.

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.

Date

Date

- 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.

Department of Health and Human Services

1/12/2021

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

TAYLOR COMMUNITY

Docustigned by:

Middle Flakerty

Name: Michael Flakerty

President and CEO

Title:

State of New Hampshire

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 \$155,400.00, for the number of test listed in Section 4.
- 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.
- 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.



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

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

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4) Reimburse	ement type (please check all that a	ipply):				
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Oi	utbreak/Response			٠.		
□ C₀	ounty rate greater than 5%					
☐ C ₀	ounty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
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1/11/2021

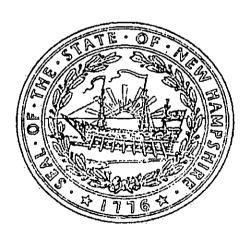
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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 1D: 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

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

Signature of Elected Officer

Name: RONALD A. BAKER

Title: Treasurer

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). CONTACY NAME: Jill Martineau Melcher & Prescott Insurance (803) 524-4535 426 Main Street ADDRESS: imartineau@melcher-prescott.com INSURER/S) AFFORDING COVERAGE NAIC # Laconia NH 03246 Cincinnati Insurance Co. INSURER A: INSURED INSURER B: NH Employers Insurance Co. 13083 Taylor Community INSURER C 435 Union Avenue INSURER D : NSURER E : NH 03246 Laconia INSURER F: COVERAGES CL20102105897 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. MODE SUBR TYPE OF INSURANCE PÓLICY NUMBER COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE CLAIMS-MADE X OCCUR 100,000 PREMISES (Ea occurrence) 5,000 MED EXP (Any one person) HCF0008520 05/01/2020 05/01/2021 1,000,000 PERSONAL & ADV INJURY 2.000.000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE PRO-JECT 2,000,000 POLICY PRODUCTS - COMP/OP AGG 1,000,000 OTHER: Cosmetologist AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT \$ 1,000,000 (En accident ANY AUTO BOOKY INJURY (Per person) SCHEDULED AUTOS NON-OWNED AUTOS ONLY OWNED AUTOS ONLY HFA0006417 05/01/2020 05/01/2021 BOOLY INJURY (Per accident) PROPERTY DAMAGE HIRED AUTOS ONLY \$ 1,000,000 UnderInsured motorist UMBRELLA LIAB OCCUR EACH OCCURRENCE EXCESS LIAB HCF0008520 05/01/2020 05/01/2021 CLAIMS-MADE AGGREGATE DED RETENTION & WORKERS COMPENSATION X PER STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? 1.000.000 В ELL EACH ACCIDENT WMZ80080069372020A 10/01/2020 10/01/2021 1,000,000 E.L. DISEASE - EA EMPLOYEE f yes, describe under DESCRIPTION OF OPERATIONS below 1,000,000 E.L. DISEASE - POLICY LIMIT DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES (ACORD 101, Additional Remarks Schedule, may be stached 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. State of NH, Department of Health & Human Services 129 Pleasant St AUTHORIZED REPRESENTATIVE He M Musterien Concord NH 03301

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.</p>
 - 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.

12/22/2020

12/22/2020

Date

Date

- 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.

State of New Hampshire

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

Name: Title:

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

THE COURVILLE AT NASHUA, INC

DocuSigned by:

Courville

Department of Health and Human Services

THE COURVILLE AT NASHUA, INC SS-2021-DPHS-11-LONGT-47-A01

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.
- 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
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- 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.

Date 12/22/2020

1) Name of facility:



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

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

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 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): Anoth for reimbursement period: Select Month Week 1 Test Date Week 1 Second Test Date (if applicable) Tested (if applicable) Rate Reimbursement Amount \$100/Test Week 2 Test Date Week 3 Second Test Date (if applicable) Tested (if applicable) Rate Reimbursement Amount \$100/Test Residents Tested (if applicable) \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Reimbursement Amount \$100/Test Rate Amount \$100/Test Rate Amount Amount \$100/Test Rate Reimbursement Amount \$100/Test Rate Amount Amount \$100/Test Rate Reimbursement Amount Amount \$100/Test Rate Reimbursement Amount Amount \$100/Test Rate Reimbursement Amount Amount \$100/Test Rate Amount Amount \$100/Test Rate Amount Amount \$100/Test Rate Amount Amount \$100/Test Rate Amount Amount \$100/Test Rate Amount Amount \$100/Test Rate Amount Amount Amount \$100/Test			. 1 0			
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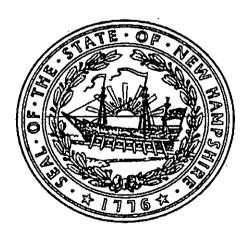
State of New Hampshire Department of State

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
RESOLVED: That Ryan Courville (" <u>Mr. Ryan Courville</u> "), 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.



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(les) 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 PHONE (A/C, No. Ext): E-MAIL Cross Insurance - Lewiston (207) 783-8591 (207) 783-3852 150 Mill Street sdwelley@crossagency.com ADDRESS: Fourth Floor, Suite 4 INSURER(S) AFFORDING COVERAGE NAIC # Lewiston MF 04240-3101 Medical Mutual Ins Company of Maine INSURER A: INSURED Massachusetts Bay Ins Co 22306 INSURER B : The Courville Company, Inc. AmGuard Ins Co. 42390 INSURER C : 175 River Road INSURER D : INSURER E : Manchester NH 03104 INSURER F : COVERAGES CL205721901 **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 ADDLISUBR POLICY EFF POLICY EXP TYPE OF INSURANCE POLICY NUMBER LIMITS COMMERCIAL GENERAL LIABILITY 1,000,000 EACH OCCURRENCE DAMAGE TO RENTED CLAIMS-MADE X OCCUR 100,000 PREMISES (Ea occurrence) \$5,000 Each Event Ded/\$25K Agg 5,000 MED EXP (Any one person) NHNHL002265 05/01/2020 05/01/2021 .1,000,000 PERSONAL & ADV INJURY 3,000,000 GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE PRO-JECT > POLICY 1,000,000 PRODUCTS - COMP/OP AGG OTHER: Professional Liab - Each \$ 1,000,000 **AUTOMOBILE LIABILITY** GOMBINED GINGLE LIMIT s 1,000,000 (Ea accident) ANY AUTO **80DILY INJURY (Per person)** s OWNED AUTOS ONLY HIRED AUTOS ONLY В SCHEDULED ADP2868404 05/01/2020 05/01/2021 BODILY INJURY (Per accident) \$ AUTOS NON-OWNED PROPERTY DAMAGE (Per accident) ALITO'S ONLY Medical payments s 5,000 UMBRELLA LIAB OCCUR 9,000,000 **EACH OCCURRENCE** EXCESS LIAB NHUMB004470 05/01/2020 05/01/2021 9,000,000 CLAIMS-MADE **AGGREGATE** DED | RETENTION \$ 10,000 WORKERS COMPENSATION STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) if yes, describe under DESCRIPTION OF OPERATIONS below 500,000 C E.L. EACH ACCIDENT N N/A COWC196561 05/01/2020 05/01/2021 500,000 E.L. DISEASE - EA EMPLOYEE 500,000 E.L. DISEASE - POLICY LIMIT Each Loss Limit 1.000 000 Prof Liab-Claims Made: 5/1/20 Retro NHNHL002265 05/01/2020 \$5,000 each loss ded / \$25K agg ded 05/01/2021 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 Departm Office of Operations Support	ent of Health & Human	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
129 Pleasant St.		AUTHORIZED REPRESENTATIVE
Concord	NH 03301	Summ Duellar

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AGENCY CUSTOMER ID: 00038075 LOC#:

ACORD

ACORD AD	DITIONAL REM	ARKS SCHEDULE	Page of
AGENCY		NAMED INSURED	
Cross Insurance - Lewiston		The Courville Company, Inc.	
POLICY NUMBER			
CARRIER	NAIC CODE		
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ADDITIONAL REMARKS			
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ACORD 101 (2008/01)

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

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.

12/22/2020 -

12/22/2020

Date

Date

- 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.

State of New Hampshire

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

Name: Title:

Docusigned by:

I was M. Mowie

Name: Director, Division of Public Health Srvcs.

THE COURVILLE AT MANCHESTER, LLC

Docusigned by:

Name: Name: Docusigned by:

Name: Na

Department of Health and Human Services

THE COURVILLE AT MANCHESTER, LLC SS-2021-DPHS-11-LONGT-10-A01

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.
- 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.

Date 12/22/2020

Name



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

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

	acility:				
2) How man	y staff members does your facility	have?			
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3) Staff testin	ng lab utilized:		' 		
4) Reimburs	ement type (please check all that a	npply):			
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Week 3 Test Date	Week 3 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	\$100/Test	Amount Reimbursement Amount
Week 3 Test Date	1		Residents Tested	<u> </u>	Reimbursement
Week 3 Test Date Week 4 Test Date	(if applicable) Week 4 Second Test Date	Tested Total Staff	Residents Tested (if applicable)	Rate	Reimbursement Amount Reimbursement
	(if applicable)	Tested	Residents Tested (if applicable)	Rate \$100/Test Rate	Reimbursement Amount
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12/22/2020

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 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:

that:	
1. I am a duly elected President of La Quinta Holdings I, Inc., the	e Manager of The Courville at Manchester, L.L.C.
2. The following is a true copy of a resolution duly adopted by commanager of The Courville at Manchester, L.L.C. on	onsent resolutions in lieu of a meeting of the imber 22, 2020.
RESOLVED: That Ryan Courville ("Mr. Ryan Courville"), as Vin Manager of The Courville at Manchester, L.L.C., is duly authorize Manager of The Courville at Manchester, L.L.C., to enter into conformal Hampshire and any of its agencies or departments and that Mr. and all documents, agreements and other instruments, and any which may, in his judgment, be desirable or necessary to effect	zed on behalf of La Quinta Holdings I, LLC, as the ontracts or agreements with the State of New Ryan Courville is further authorized to execute any amendments, revisions, or modifications thereto,
3. I hereby certify that said resolution has not been amended or the date of the contract/contract amendment to which this certification thirty (30) days from the date of this Certificate of Authority. I follow Hampshire will rely on this Certificate of Authority as occupies the position indicated and that he has full authority to the Courville at Manchester, L.L.C. To the extent that there are to bind the corporation in contracts with the State of New Hamberein.	icate is attached. This authority remains valid for further certify that it is understood that the State of evidence that the person listed above currently bind La Quinta Holdings I, LLC, as the Manager of e any limits on the authority of any listed individual
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



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).

tŀ	ils certificate does not confer rights to	the co	ertific	cate holder in lieu of such							
PRO	DUCER				CONTAC NAME:	Susan Dw	elley/		_		
Cross Insurance - Lewiston			PHONE (A/C. No	Ext): (207) 78	33-8591		FAX (A/C, No):	(207) 7	83-3852		
150 Mill Street			E-MAIL ADDRE	edwallaw	crossagency.	com					
Fourth Floor, Suite 4					SURER(S) AFFOR	IDING COVERAGE			NAIC #		
Lev	viston .			ME 04240-3101	INSURE	Madiaal		npany of Maine			
INSU	RED				INSURE	Massas	usetts Bay Ins	Co		\dashv	22306
	The Courville Company, Inc.				INSURE	AC					42390
	175 River Road					к.		·- ·- · · ·			
					INSURE		 -			-	.
	Manchester			NH 03104	INSURE						
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	DED RETENTION \$ 10,000							NOO! LEONIE		s	
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_	AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE N			00000000				E.L. EACH ACCIDEN		s 500.0	000
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•	AGENCY CUSTOMER ID: 00038075			
	LOC#:			
ACORDO	ADDITIONAL REMARKS SCHEDULE	Paga	of	

AGENCY Cross Insurance - Lewiston		NAMED INSURED The Courville Company, Inc.		
POLICY NUMBER			•	
CARRIER	NAIC CODE	EFFECTIVE DATE:		
ADDITIONAL REMARKS		1		
THIS ADDITIONAL REMARKS FORM IS A SCHE	DULE TO ACORD FORM,			
FORM NUMBER: 25 FORM TITLE: G	Certificate of Liability Insurance			
RE: Surveyors				
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ACORD 101 (2008/01)

Additional Named Insureds

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			

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.</p>
 - 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	Docusigned by: Then M. Movvis
Date	Name Name Manager
	Title: Director, Division of Public Health Srvcs.
	THE MORRISON HOSPITAL ASSOCIATION
•	Cousigned by:
12/21/2020	louise Belanger
Date	Name: Louise Be langer
	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.
- 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.



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

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

I) Name of fa	acility:					
2) How many	staff members does your facility	have?				
3) Staff testin	g lab utilized;					
4) Keimburse	ment type (please check all that a	ipply):		•		
Su	rveillance					
Ou	ntbreak/Response					
Пс	unty rate greater than 5%					
_						
C₀	unty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	esting lab utilized (if different from	m staff and outbro	eak/response is checked) :		
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Week 4 Test Date	Week 4 Second Test Date (if applicable)	Total Staff Tested	Residents Tested (if applicable)	Rate	Reimbursement Amount	
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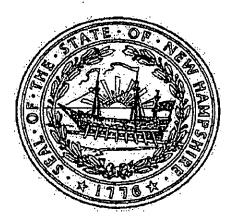
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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. (Name of the elect	Shearer	President	heret	by certify that:	
(Maine of the elect	ed Officer of the Corp	oration/LLC, cann	or be contract sign	iatory)	
1. I am a duly elected Cleri	k/Secretary/Officer of	Marriso2 (Corporation/LLC	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Association.	
2. The following is a true c held on <u>〜〜〜〜〜〜〜〜〜</u>	opy of a vote taken at , 20 <u></u> , at which (Date)	a meeting of the I	Board of Directors Directors/sharehold	/shareholders, duly called ders were present and vo	l and ting.
VOTED: That \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Belower F d Title of Cofftract Sig	tecutive Dir	ector (ma	y list more than one perso	on)
is duly authorized on beha	If of Movn'son Hosy (Name of Corp	to oration/ LLC)	enter into contrac	ts or agreements with the	State
of New Hampshire and a documents, agreements a may in his/her judgment be	and other instruments	s, and any amend	lments, revisions,	or modifications thereto	and all
3. I hereby certify that said date of the contract/contra	act amendment to widate of this Certificate on this certificate as that they have full among listed individual to	hich this certificate e of Authority. I fund s evidence that the uthority to bind the	e is attached. Thi ther certify that it ie person(s) listed e corporation. To	s authority remains vali is understood that the Sta d above currently occup the extent that there are	d for ate of y the e any
Dated: 12/22/2020		_	Double a	. Shearer .	
		:	Signature of Elect	ed Officer	
			Name: Douglas	A. Shearen	
		•	Title: President	٠.	

DRIOUX

ACORD'

CERTIFICATE OF LIABILITY INSURANCE

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.

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	Concord Street thus, NH 03064					ss: drioux@	eatonberu	l (A/C, No): be.com	_	
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	DED RETENTIONS								•	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						-	PER OTH-	*	
	ANY PROPRIETOR/PARTNER/EXECUTIVE							E.L. EACH ACCIDENT	•	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A						E.L. DISEASE - EA EMPLOYEE		
	If yes, describe under DESCRIPTION OF OPERATIONS below			ļ				E.L. DISEASE - POLICY LIMIT		
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Α	Liability		ŀ	NHNHL002394		5/23/2020	5/23/2021	Aggregate		3,000,000
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	129 Pleasant Street Concord, NH 03301					RIZED REPRESEI				

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(les) must have ADDITIONAL INSURED provisions or be endorsed.

	SUBROGATION IS WAIVED, subject is certificate does not confer rights to							require an endorsement.	. A st	atement on
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	rfax VA 22030				E-MAJL ADORE			11,491,191		
	,						URER(S) AFFOR	DING COVERAGE		NAIC#
				THEMO-1	INSURE	RA: A.I.M. M	utual Insuran	ce Compan		
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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										
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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

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). CONTACT PRODUCER PHONE (A/C, No, Ext): (603) 444-3975 Hunkins & Eaton Agency Inc FAX (A/C, No): (603) 444-1131 93 Main Street Littleton, NH 03561 INSURER(S) AFFORDING COVERAGE NAIC # INSURER A : Philadelphia Insurance Companies 23850 INSURED INSURER B : Morrison Hospital Association INSURER C : 6 Terraca St. INSURER D Whitefield, NH 03598 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. POLICY EFF POLICY EXP ADDL SUBR TYPE OF INSURANCE POLICY NUMBER LIMITS COMMERCIAL GENERAL LIABILITY EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) CLAIMS-MADE OCCUR MED EXP (Any one person) PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE PRO-JECT POLICY LOC PRODUCTS - COMPIOP AGG OTHER: COMBINED SINGLE LIMIT 1,000,000 AUTOMOBILE LIABILITY ANY AUTO PHPK2134409 5/23/2020 5/23/2021 BODILY INJURY (Per person) OWNED AUTOS ONLY SCHEDULED AUTOS BODILY INJURY (Per accident)
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(Per accident) X HIRED ONLY MONSONED UMBRELLA LIAB OCCUR EACH OCCURRENCE **EXCESS LIAB** CLAIMS-MADE AGGREGATE RETENTION \$ WORKERS COMPENSATION AND EMPLOYERS' LIABILITY PER STATUTE ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) E.L. EACH ACCIDENT N/A E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT 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 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. NH Department of Health & Human Services 129 Pleasant St Concord, NH 03301 AUTHORIZED REPRESENTATIVE

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</p>
 - 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	Trea M. Morris
Date	Name Lisa M. Morris
	Title: Director, Division of Public Health Srvcs.
	THE PROSPECT WOODWARD HOME
	DocuSigned by:
12/21/2020	Mary Ellen Dunham
Date	Name Mary Ellen Dunham

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 \$ 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.

1) Name of facility:



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

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

2) How man	y staff members does your facility	have?			
l l		1			
3) Staff testi	ng lab utilized:				
4) Reimburs	ement type (please check all that a	ipply):		•	
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١٥	utbreak/Response				
c	ounty rate greater than 5%			e Aliente.	
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5) How man	y residents does your facility have	? (if outbreak/res	ponse is checked)		
6) Resident	esting lab utilized (if different fro	m staff and outbre	eak/response is checked):	
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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 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 duty 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

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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.

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). CONTACT NAME: Arthur J. Gallagher Risk Management Services, Inc. PHONE (A/C, No, Ext): 312-704-0100 (AC, No): 312-803-7443 2850 Golf Road Rolling Meadows IL 60008 ADDRESS INSURER(S) AFFORDING COVERAGE NAIC # INSURER A: Zurich American Insurance Company 16535 INSURED LCSHOLD-03 INSURER B: Ironshore Specialty Insurance Co 25445 Hillside Village Keene The Prospect-Woodward Home INSURER C : Hiscox Insurance Company Inc. 10200 95 Wyman Road INSURER D : Keene NH 03431 INSURER E INSURER F : **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 ADDL SUBR INSR LTR POLICY EFF (MM/DD/YYYY) POLICY EXP TYPE OF INSURANCE LIMITS POLICY NUMBER (MM/DD/YY 8 Х COMMERCIAL GENERAL LIABILITY 004052801 6/30/2020 6/30/2021 EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) X CLAIMS-MADE OCCUR \$ 50,000 Х Policy Agg MED EXP (Any one person) \$ 10,000 Х \$27,500,000 PERSONAL & ADV INJURY \$1,000,000 GEN'L AGGREGATE LIMIT APPLIES PER **GENERAL AGGREGATE** \$ 3,000,000 PRO-JECT | X | LOC POLICY PRODUCTS - COMP/OP AGG \$3,000,000 OTHER 50 Deductible COMBINED SINGLE LIMIT (Ea accident) AUTOMOBILE LIABILITY RAP 4192983-02 6/30/2020 6/30/2021 \$1,000,000 ANY AUTO BODILY INJURY (Per person) S OWNED AUTOS ONLY HIRED SCHEDULED AUTOS NON-OWNED BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ **AUTOS ONLY AUTOS ONLY** Х CompDed:\$500 CollDed:\$500 В X UMBRELLA LIAB 004053001 6/30/2020 6/30/2021 OCCUR **EACH OCCURRENCE** \$ 10,000,000 **EXCESS LIAB** Х CLAIMS-MADE **AGGREGATE** \$ 50,000,000 DED RETENTION \$ \$ 10,000,000 WORKERS COMPENSATION AND EMPLOYERS' LIABILITY WC4192984-02 6/30/2020 6/30/2021 PER <u>STATUT</u>E ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT \$ 500,000 (Mandatory in NH) \$ 500,000 E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT \$ 500,000 Ç UC24457814.20 Limit of Liability Per Claim \$3,000,000 Crime Prof Llab (Claims Made) 6/30/2021 6/30/2020 004052801 6/30/2020 6/30/2021 \$1,000,000 \$3,000,000 Aggregate 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** 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. DHHS 129 Pleasant Street AUTHORIZED REPRESENTATIVE Concord NH 03301

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.</p>
 - 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.

State of New Hampshire

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

	Department of Health and Human Services
1/4/2021	Docysigned by: There M. Movvis
Date	Name:
	Title: Director, Division of Public Health Srvcs
•	The Riverwoods Group
	DocuSigned by:
1/4/2021	Justine Vogel
Date	Name: 90817916 Voge I
	Title: CEO

Exhibit A-2, Amendment 1 Facility List

Facility Name	Vendor 0	Total TESTS	Reiml	bursement 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 1

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

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.
- 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 <a href="https://lieu.org/lieu.nc/lieu.org/



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

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

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3) Staff testir	g lab utilized:					
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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 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/	LC; cannot be contract signatory)
I am a duly elected Clerk/Secretary/Officer of The River (Corporal)	erWoods Group. tion/LLC Name)
2. The following is a true copy of a vote taken at a meetineld on January 4, 2021, at which a quorum of the Direct (Date)	ng of the Board of Directors/shareholders, duly called and tors/shareholders were present and voting.
VOTED: That Justine Vogel, CEO and TRWG Board Cle (Name and Title of Contract Signatory)	erk (may list more than one person)
is duly authorized on behalf of The RiverWe agreements with the State (Name of Corpo	pods Group to enter into contracts or oration/ LLC)
of New Hampshire and any of its agencies or depart documents, agreements and other instruments, and armay in his/her judgment be desirable or necessary to eff	tments and further is authorized to execute any and a ny amendments, revisions, or modifications thereto, which ect the purpose of this vote.
date of the contract/contract amendment to which this thirty (30) days from the date of this Certificate of Authonous Hampshire will rely on this certificate as evidence position(s) indicated and that they have full authority to	or repealed and remains in full force and effect as of the certificate is attached. This authority remains valid for prity. I further certify that it is understood that the State of the that the person(s) listed above currently occupy the point the corporation. To the extent that there are any corporation in contracts with the State of New Hampshire.
Dated:1/4/2021	Signature of Elected Officer
	Name: Beth Roberts
	Title: TRWG Board Chair

Rev. 03/24/20



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).

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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.

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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.

State of New Hampshire

Department of Health and Human Services

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

12/31/2020

Date

Docusigned by:
Name:
Name:
Director, Division of Public Health Srvcs.

UNITED CHURCH OF CHRIST RETIREMENT
COMMUNITY

12/31/2020

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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 \$211,200.00, for the number of test listed in Section 4.
- 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
	.1

- 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.



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

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

How many	staff members does your facility	have?				
2) Su-Manie	a lab addicada					
3) Staff testin	g lab utilized:					
4) Reimburse	ment type (please check all that a	pply):			•	
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	itbreak/Response					
Co	ounty rate greater than 5%					
Cc	ounty rate greater than 10%					
5) How many	residents does your facility have	? (if outbreak/res	ponse is checked)			
6) Resident to	esting lab utilized (if different from	m staff and outbre	eak/response is checked):		
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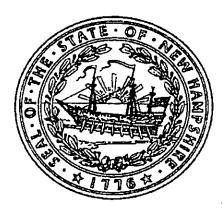
State of New Hampshire **Department of State**

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that THE 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 hereby certify that: Officer of the Corporation/LLC; cannot be contract signatory) 1. I am a duly elected Clerk/Secretary/Officer of M. Willo Charlet & Char handle Grant 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 a could 31 , 20 යුර , at which a quorum of the Directors/shareholders were present and voting. (Date) (may list more than one person) is duly authorized on behalf of TILUMILD CHURCH of CIRLST (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.

Signature of Elected Officer
Name: Ham MARIX John Kas
Title: Standard Marix John Kas

Rev. 03/24/20

Client#: 491851

UCCRCINC

ACORD. CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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Concord, NH 03301

AUTHORIZED REPRESENTATIVE

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	Docusigned by: (Fight M. Mowis
Date	Name: Lisa M. Morris
	Title: Director, Division of Public Health Srvcs.
	VILLA CREST HEALTHCARE CENTER LLC
	DocuSigned by:
12/28/2020	karyn Miner
Date .	Name: Karyn Miner
	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 \$ 96,000.00, for the number of test listed in Section 4.
- 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			
1				

- 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.

1) Name of facility:



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

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

3) Staff testin	g lab utilized:					
4) Reimburse	ment type (please check all that a	 pply):				
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6) Resident te	sting lab utilized (if different from	n staff and outbro	eak/response is checked)) :		
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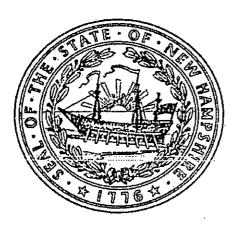
State of New Hampshire Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that 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

1, Allian Puruin, 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 Ville Gest Ita In 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 the long of the Directors/shareholders were present and very (Date)	ed and oting.
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is duly authorized on behalf of Ville West Hall (e. to enter into contracts or agreements with the (Name of Corporation/ LLC)	e State
of New Hampshire and any of its agencies or departments and further is authorized to execute any documents, agreements and other instruments, and any amendments, revisions, or modifications theret 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 date of the contract/contract amendment to which this certificate is attached. This authority remains va thirty (30) days from the date of this Certificate of Authority. I further certify that it is understood that the SNew Hampshire will rely on this certificate as evidence that the person(s) listed above currently occuposition(s) indicated and that they have full authority to bind the corporation. To the extent that there a limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampall such limitations are expressly stated herein. Dated: 15121 Signature of Elected Officer Name: Alizon t. Burnititle: Munagur	lid for tate of py the re any

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INSU	RED		INSURER A: Pron	nier Plus Insuran	ce Company, LTD				
, N	sational HealthCare Corporatio	n	INSURER B:						
	00 E. Vine Street	••	INSURER C:						
N	Aurfreesboro, TN 37130		INSURER D:		<u> </u>				
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A	CLAIMS MADE OCCUR		01/01/2021	01.01.2022	MED EXP (Any one person)	Excluded			
l	Professional Liability				PERSONAL & ADV INJURY	Included			
\	Premises Liability				GENERAL AGGREGATE	3,000,000.			
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	moord, IIII 00001		AUTHORIZED REPRESENTATIVE Paul Macey						
ÄĆ	ord/25'\$(6/1978)\$\$		TANK SHE'S AND LONG PARTICULAR OF THE PARTICULAR						

Certificate No

Holder Identiller:

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.</p>
 - 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

Srvcs.

12/23/2020	Tien M. Morris
Date	Name: Lisa M. Morris
	Title: Director, Division of Public Health
	VK DOVER LLC
	DocuSigned by:
12/23/2020	tara Verge
Date	Name: Tara Verge
	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 \$ 93,900.00, for the number of test listed in Section 4.
- 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.

Week 5 Test Date

(if applicable)

Week 5 Second Test Date

(if applicable)



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

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

I) Name of f	acility:									
2) How many	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);										
testing tab defized (if different from staff and outbreak/response is enecked):										
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					
										

<u></u> .				
Name	Title	1	Date —	12/23/2020
	`			

Residents Tested

(if applicable)

Total Staff

Tested

\$100/Test

Rate

\$100/Test

Reimbursement

Amount

One Click Certificate of Good Standing















Search Business

Business Information

Payment

Done

Business Details

Business Name: VK DOVER, LLC

Foreign Limited Liability

Business Type:

Business Creation 01/18/2013 Date:

Name in State of VK DOVER, LLC Formation:

Business Status: Good Standing

Business ID: 685455

Date of Formation in 01/18/2013

Principal Office 20 East Sunrise Highway, Valle Mailing Address: 20 East Sunrise Highway, Valley

Address: y Stream, NY, 11581, USA

Stream, NY, 11581, USA

Citizenship / State of Foreign/Delaware

Last Annual 2020

Report Year:

Next Report 2021

Year:

Duration: Perpetual

Business Email: tmueller@nathealthcare.com

Phone #: 516-705-4800

Notification Email: tmueller@nathealthcare.com

Fiscal Year End NONE Date:

Acknowledgment will be sent to the business email on record unless otherwise requested.

Ш	I would like tr	ne acknowleagment 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 -- <u>Contact Us</u> <u>(/online/Home/ContactUS)</u>

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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. Osfreicher Title: Managing Member Client#: 1421981

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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).

th	is certificate does not confer any rigi	nts to	the	certificate holder in lieu d			nt(s).					
PRO	DUCER				CONTACT							
USI	Insurance Services LLC				PHONE (A/C, No, Ext): 855 874-0123 (A/C, No): 203 634-5701							
530	Preston Avenue				E-MAIL ADDRESS:							
Mei	riden, CT 06450											
855	874-0123				INSURER(S) AFFORDING COVERAGE						13589	
INSU	PEN			•	INSURER A: MedPro RRG Risk Retention Group						13309	
	Dover Center for Health &	Reh	abili	taon	INSURE							
	c/o National Health Care A	SSO	ciate	s. Inc	INSURE							
	20 East Sunrise Hwy. 2nd			,	INSURE							
ŀ	Valley Stream, NY 11581	•			INSURE							
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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 CANCELLATION												
1												

State of NH
Department of Health and Human Services

129 Pleasant Street Concord, NH 03301-3857 SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

John J. Ulacka

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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.

DOVERCEN

ACORD...

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/02/2020

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). RODUCER CONTACT USI Insurance Services LLC PHONE (A/C, No, Ext): 855 874-0123 E-MAIL ADDRESS: FAX (A/C, No): 203 634-5701 530 Preston Avenue Meriden, CT 06450 INSURER(S) AFFORDING COVERAGE NAIC # 855 874-0123 INSURER A : MEMIC Indemnity Co 11030 INSURED INSURER B Dover Center for Health and INSURER C Rehabilitation; 20 East Sunrise Highway INSURER D : Valley Stream, NY 11581 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. ADDL SUBR TYPE OF INSURANCE POLICY EFF POLICY EXP (MM/DD/YYYY) (MM/DD/YYYY POLICY NUMBER LIMITS COMMERCIAL GENERAL LIABILITY **EACH OCCURRENCE** DAMAGE TO RENTED PREMISES (Ea occurrence) CLAIMS-MADE OCCUR MED EXP (Any one person) PERSONAL & ADV INJURY GEN'L AGGREGATE LIMIT APPLIES PER: GENERAL AGGREGATE POLICY PRODUCTS - COMP/OP AGG OTHER: AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT ANY AUTO BODILY INJURY (Per person) SCHEDULED OWNED AUTOS ONLY BODILY INJURY (Per accident) AUTOS NON-OWNED AUTOS ONLY \$ HIRED AUTOS ONLY PROPERTY DAMAGE (Per accident) \$ UMBRELLA LIAB OCCUR **EACH OCCURRENCE** \$ EXCESS LIAB CLAIMS-MADE AGGREGATE DED RETENTION \$ WORKERS COMPENSATION 5101800620 07/01/2020 07/01/2021 X STATUTE AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? E.L. EACH ACCIDENT \$1,000,000 Ν (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE \$1,000,000 If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT s1,000,000 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 State of NH THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN Department of Health and Human Services ACCORDANCE WITH THE POLICY PROVISIONS. 129 Pleasant Street AUTHORIZED REPRESENTATIVE Concord, NH 03301-3857

John & Ulacka