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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6527
603-271-4501 1-800-852-3345 Ext. 4501
Fax: 603-271-4827 TDD Access: 1-800-735-2964

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

Nicholas A. Toumpas
Commissioner

Marcella Jordan Bobinsky
Acting Director

May 5, 2015

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

Sole Source

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to enter into a **sole source** agreement with Lamprey Health Care, Vendor #177677-R001, 207 South Main Street, Newmarket, NH 03857, in an amount not to exceed $532,902, to provide regional public health emergency preparedness, substance use disorders continuum of care, and Public Health Advisory Council coordination, to be effective July 1, 2015 or date of Governor and Council approval, whichever is later, through June 30, 2017. 97.15% Federal and 2.85% General.

Funds are anticipated to be available in SFY 2016 and SFY 2017 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from Governor and Executive Council.

05-95-49-491510-2988 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, DIVISION OF COMMUNITY BASED CARE SERVICES, BUREAU OF DRUG AND ALCOHOL SERVICES, PREVENTION SERVICES

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2016	102-500731	Contracts for Prog Svc	49156502	165,380
SFY 2017	102-500731	Contracts for Prog Svc	49156502	165,380
			Sub Total	$330,760

05-95-90-901010-5362 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF PUBLIC HEALTH SYSTEMS, POLICY & PERFORMANCE, POLICY & PERFORMANCE

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2016	102-500731	Contracts for Prog Svc	90001022	15,000
SFY 2017	102-500731	Contracts for Prog Svc	90001022	15,000
			Sub Total	$30,000

05-95-90-902510-7545 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF INFECTIOUS DISEASE CONTROL, EMERGENCY PREPAREDNESS

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2016	102-500731	Contracts for Prog Svc	90077021	52,271
SFY 2017	102-500731	Contracts for Prog Svc	90077021	52,271
			Sub Total	$104,542

05-95-90-902510-7545 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, BUREAU OF INFECTIOUS DISEASE CONTROL, EMERGENCY PREPAREDNESS

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2016	102-500731	Contracts for Prog Svc	90077026	33,800
SFY 2017	102-500731	Contracts for Prog Svc	90077026	33,800
			Sub Total	$67,600
			TOTAL	$532,902

EXPLANATION

This request is **sole source** because the Town of Exeter has elected not to continue to participate as a Public Health Network site (see attached letter of withdrawal), and there was a need to establish a replacement provider for that area to ensure continuity of service. There are 13 Public Health Network sites across the State that each serves a defined Public Health Region. Every municipality in the State is assigned to a Public Health Region. The Seacoast Public Health Advisory Council, which is comprised of leaders from the leading health and human services provider agencies located on the Seacoast identified Lamprey Health Care as their vendor of choice because its current program and service array made it particularly well-positioned to assume leadership of this effort (see attached letter of support). Requests to extend the current agreements with five (5) Public Health Network sites were presented at a previous Governor and Council meeting. The remaining seven (7) will be presented at upcoming Governor and Executive Council meetings.

Funds in this agreement will be used to provide regional public health emergency preparedness, substance use disorders continuum of care, and host a Public Health Advisory Council to coordinate other public health services in a specific geographic area.

The Regional Public Health Advisory Council will engage senior-level leaders from throughout this region to serve in an advisory capacity over the services funded through this agreement. Over time, the Division of Public Health Services and the Bureau of Drug and Alcohol Services expect that the Regional Public Health Advisory Councils will expand this function to other public health and substance use disorders continuum of care services funded by the Department. The long-term goal is for the Regional Public Health Advisory Councils to set regional priorities that are data-driven, evidence-based, responsive to the needs of the region, and to serve in this advisory role over all public health and substance use disorders continuum of care activities occurring in the regions.

The vendors will lead a coordinated effort with regional public health, health care and emergency management partners to develop and exercise regional public health emergency response plans to improve the region's ability to respond to public health emergencies. These regional activities are integral to the State's capacity to respond to public health emergencies.

According to the 2012-2013 National Survey on Drug Use and Health[1], the most recent data available demonstrates that 49% of NH's 18-25 year olds reported binge drinking in the past 30 days. This rate is the third highest in the country and much higher than the national average of 38.7%. For pain reliever abuse, 10.5% of NH young adults reported this behavior in the past year, and 10% of young adults reported illicit drug use other than marijuana. This last prevalence indicator is important for several reasons. First, it is the most accessible data point relative to young adult opioid use because the illicit drug use indicator includes opioids. Secondly, NH's rate of 10% for 18-25 year olds reporting regular illicit drug use is the highest in the country and is 1.5 percentage points higher than the next closest state (Rhode Island, 8.6%) and higher than the national average of 6.9%. Furthermore, there were five times greater the number of heroin-related deaths in NH in 2014 than there were in 2008. Heroin-related Emergency Department visits and administrations of naloxone to prevent death from an overdose have also multiplied exponentially in the last two years. Consequently, alcohol and drug misuse cost NH more than $1.84 billion in 2012 in lost productivity and earnings, increased expenditures for healthcare, and public safety costs. In addition to economic costs, substance misuse impacts and is influenced by poor mental health. From 2007 to 2011, suicide among those aged 10-24 was the second leading cause of death for NH compared to the third leading cause nationally.

In NH, youth have rates of substance use significantly higher than the national average and the other northeast (NE) states as demonstrated in Table 2.

Table 2: NH Substance Use Disorder Higher than National Average

18-25 year olds	NH	NE	US	Significant differences
Binge Drinking	49.0%	43.0%	38.7%	NH Higher than NE and US
Marijuana Use	27.8%	21.0%	18.9%	NH Higher than NE and US
Nonmedical use of pain relievers	10.5%	8.6%	9.5%	No significant difference
Dependent/abusing alcohol or illicit drugs	23.7%	19.1%	18.1%	NH Higher than NE and US

Youth and families across NH describe having little access to services and supports for Substance Use Disorder in NH. In fact, according to the National Survey on Drug Use and Health[2], NH ranks worst among the states in percentage of 18-25 year olds "needing but not receiving treatment" for alcohol or illicit drug use and is also among the bottom states for 12-17 year olds. Additionally, among 12-20 year olds, NH ranks highest and above the overall national average in both underage alcohol use in past month (NH: 35.72%, US: 23.52%) and underage binge alcohol use in past month (NH: 23.21%, US: 14.75%).

[1] 1 Source: http://www.new-futures.org/sites/default/files/Summary%20Report_0.pdf

[2] 2 Source: http://www.dhhs.nh.gov/dphs/suicide/documents/annual-report-2013.pdf

Should Governor and Executive Council not authorize this Request, both public health and substance use disorder continuum of care services will be less coordinated and comprehensive in this public health region. Developing a strong, regionally-based infrastructure to convene, coordinate, and facilitate an improved systems-based approach to addressing these health issues will, over time, reduce costs, improve health outcomes, and reduce health disparities.

The attached performance measures will be used to measure the effectiveness of the agreement:

Area served: Brentwood, East Kingston, Epping, Exeter, Fremont, Greenland, Hampton, Hampton Falls, Kensington, Kingston, New Castle, Newfields, Newington, Newmarket, Newton, North Hampton, Nottingham, Portsmouth, Raymond, Rye, Seabrook, South Hampton, Stratham.

Source of Funds: 97.15% Federal Funds from US Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration, and 2.85% General Funds.

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

Respectfully submitted,

Marcella Jordan Bobinsky
Acting Director
Division of Public Health Services

Kathleen A. Dunn, MPH
Associate Commissioner

Approved by:
Nicholas A. Toumpas
Commissioner

Attachments: Town of Exeter Letter of Withdrawal
Seacoast Public Health Advisory Council Letter of Support

TOWN OF EXETER, NEW HAMPSHIRE

10 FRONT STREET • EXETER, NH • 03833-3792 • (603) 778-0591 •FAX 772-4709
www.exeternh.gov

February 23, 2015

Mr. Nicholas Toumpas, Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord NH 03301

Dear Commissioner Toumpas:

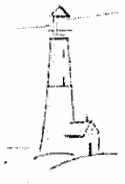
As the Seacoast Public Health Region grows and expands their public health initiatives, the Town of Exeter is unable to continue its role as the contractor. We are in full support of the work of the Seacoast Public Health Region and are looking forward to our relationship continuing with the Region, especially in emergency preparedness.

The Town of Exeter fully supports the Seacoast Public Health Advisory Council's vote to support Lamprey Health Care as the sole source contractor with the Department of Public Health Services to provide Regional Public Health Network Services in the Seacoast Public Health Region for the new contract term starting July 1, 2015.

Please feel free to contact myself or Chief Brian Comeau at the Fire Department if you have any questions.

Sincerely,

Mr. Russell Dean, Manager
Town of Exeter



SEACOAST PUBLIC HEALTH REGION

The Region includes the communities of Brentwood, East Kingston, Epping, Exeter, Fremont, Greenland, Hampton, Hampton Falls, Kensington, Kingston, New Castle, Newfields, Newmarket, Newton, Newington, North Hampton, Nottingham, Portsmouth, Raymond, Rye, Seabrook, South Hampton and Stratham.

February 24, 2015

Mr. Nicholas Toumpas, Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Toumpas:

On February 12, 2015, the Seacoast Public Health Advisory Council voted to support Lamprey Health Care entering into a sole source contract with the Department to provide Regional Public Health Network Services in the Seacoast Public Health Region. Our understanding is that the contract period will be from July 1, 2015 to June 30, 2017. Advisory Council members voting to support this action were:

Stacey Angers, Portsmouth Hospital
Patte Ardizzoni, Rockingham Community Action
Cindy Boyd, United Way of the Greater Seacoast
Brinn Chute, City of Portsmouth
Celeste Clark, Raymond Youth Coalition
Brian Comeau, Exeter Fire Department
Jay Couture, Seacoast Mental Health Center
Jim Hayes, SAU 16
Helen Taft, Families First
Greg White, Lamprey Health Care ***(Abstained)***

The Advisory Council looks forward to working with Lamprey Health Care and the Department to improve the coordination and delivery of public health services in the Seacoast Public Health Region. Please contact Sandi Coyle or Mary Cook if additional information would be of value.

Sincerely,

Mary Cook
PHAC Coordinator

Sandi Coyle
PHAC Coordinator

20 Court Street, Exeter, NH 03833 Tel: 603-418-6404 Fax: 603-773-6128
www.seacoastphr.org

Regional Public Health Advisory Committee

- Representation of at least 70% of the 11 community sectors identified in the CDC Capabilities Standards that participate in the Regional Public Health Advisory Committee.
- Representation of 65% of the 6 community sectors identified in the Governor's Commission plan that participate in the Regional Public Health Advisory Committee.
- Documented organizational structure for the Regional Public Health Advisory Committee (e.g. vision or mission statements, organizational charts, MOUs, minutes, etc.).
- Establish and increase over time regional connectivity among stakeholders and improved trust among partners via the biennial PARTNER Survey.

Substance Use Disorders, Resiliency and Recovery – Orientated Systems of Care

- Number of subject matter experts from across the Continuum of Care Services recruited and serving on the workgroup.
- Number of educational resources developed to educate the PHAC.
- Number of educational events identified by the delivery modality (face to face meeting, webinars, etc.) to educate the PHAC.
- Number of PHAC members educated.
- Submission of PHAC endorsed statement/vision on what constitutes a substance use disorder comprehensive approach for your region's system of care.

Substance Misuse Prevention (SMP) and Related Health Promotion

- Completion of 3 year substance misuse prevention plan and endorsed by Regional Public Health Advisory Committee and approved by BDAS due September 30, 2015.
- Completed an approved annual work plan reflective of new strategic plan due October 31, 2015.
- Completed monthly PWITS data entries due by the 20th business day of the following month (e.g. September data due by October 30).
- Data entry needs to align with the 3 year strategic plan for substance misuse prevention and health promotion and adhere to the PWITS Policy Guidance document
- Host at minimum 4 SMP expert team meetings annually
- Meet all Federal regulatory reporting requirements of the Substance Abuse Prevention and Treatment Block Grant.
- Participates and coordinates evaluation surveys: SMP stakeholder survey and other surveys as required.
- Participates and coordinates attendees and prepare for BDAS or DPHS site visits. At request of the state you may be asked to convene: SMP coordinator, Contract administrator, financial agent, expert team chair and others as requested.
- Attendance at SMP bi monthly meetings jointly convened by BDAS and NH Charitable Foundation.
- Maintain a SMP website with links to drugfreenh.org and Bureau of Drug and Alcohol Services.
- Provides additional information to BDAS when requested.

Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

- One full time dedicated Continuum of Care (CC) facilitator hired and completed all required trainings.
- CC facilitator establishes and convenes the Continuum of Care (CC) workgroup from across the continuum of care that includes participants from prevention, intervention, treatment and recovery. Includes Healthcare and primary care providers and behavioral health.
- Submission of meeting minutes including detailed conversations and action items, CC workgroup attendance,
- Submission of an assessment of regional continuum CC assets, gaps and barriers to service within nine (9) months of the approved contact to include:
- Identification of gaps in CC components and services that need to be developed or enhanced.
- Identification of barriers to cooperation between CC components.

- Identification of barriers to community/client access to component services.
- Submission of a plan within one (1) year of the approved contract that identifies actions to address issues in the assessment of regional continuum assets, gaps and barriers to services. workplan outlining the activities to be implemented to resolve any barriers and increase capacity of services within the region

Regional Public Health Preparedness

- Score assigned to the region's capacity to dispense medications to the population based on the CDC MCM ORR.
- Number of outreach events with entities that employ health care personnel.
- Submission of the RPHEA annually

FORM NUMBER P-37 (version 1/09)

Subject: Regional Public Health Network Services

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services Division of Public Health Services		**1.2 State Agency Address** 29 Hazen Drive Concord, NH 03301-6504	
1.3 Contractor Name Lamprey Health Care		**1.4 Contractor Address** 207 South Main Street Newmarket, NH 03857	
1.5 Contractor Phone Number 603-292-7214	**1.6 Account Number** 05-95-90-902510-7545-102-500731, 05-95-90-5362-102-500731, 05-95-49-491510-2988-102-500731	**1.7 Completion Date** 06/30/2017	**1.8 Price Limitation** $532,902
1.9 Contracting Officer for State Agency Eric D. Borrin, Director Contracts and Procurement Unit		**1.10 State Agency Telephone Number** 603-271-9558	
1.11 Contractor Signature A Ashton-Savage		**1.12 Name and Title of Contractor Signatory** Audrey Ashton-Savage, President, Board of Directors	

1.13 Acknowledgement: State of NH, County of Rockingham

On 5/1/15, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or Justice of the Peace

[Seal] **Anita R. Rozeff, Notary Public**

1.13.2 Name and Title of Notary or Justice of the Peace

My commission expires March 16, 2016

1.14 State Agency Signature	**1.15 Name and Title of State Agency Signatory** Brook Dupee, Bureau Chief
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:	Director, On:
1.17 Approval by the Attorney General (Form, Substance and Execution) By: A.H. Hazen Mgr. A.G.	On: 5/22/15
1.18 Approval by the Governor and Executive Council By:	On:

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, this Agreement, and all obligations of the parties hereunder, shall not become effective until the date the Governor and Executive Council approve this Agreement ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.
5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT B which is incorporated herein by reference.
5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.
5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.
5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

Contractor Initials: AMS
Date: 5/1/15

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

9. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.
9.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.
9.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
9.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

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

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written consent of the N.H. Department of Administrative Services. None of the Services shall be subcontracted by the Contractor without the prior written consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $2,000,000 per occurrence; and
14.1.2 fire and extended coverage insurance covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.
14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than fifteen (15) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each

Contractor Initials: AAS
Date: 5/1/15

certificate(s) of insurance shall contain a clause requiring the insurer to endeavor to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than ten (10) days prior written notice of cancellation or modification of the policy.

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

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

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

18. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire.

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

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

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

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

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

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials: AMS
Date: 5/4/15

SCOPE OF SERVICES

1. Required Services

Contract Period: July 1, 2015 through June 30, 2017

The Contractor shall:

1.1. Implement the 2015 Regional Strategic Plan for Prevention pertaining to communities in their region addressing substance misuse prevention and related health promotion as it aligns with the existing three-year outcome-based strategic prevention plan completed September 2015, located at: http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm.

1.2. Develop regional public health emergency response capabilities in accordance with the Centers for Disease Control and Prevention's (CDC's) Public Health Preparedness Capabilities: National Standards for State and Local Planning (Capabilities Standards) and as appropriate to the region.

1.3. Ensure the administrative and fiscal capacity to accept and expend funds provided by the Department of Health and Human Services' (DHHS), Division of Public Health Services (DPHS) and Bureau of Drug and Alcohol Services (BDAS) for other services as such funding may become available.

1.4. Regional Public Health Advisory Committee

1.4.1. Continue a regional Public Health Advisory Committee (PHAC) comprised of representatives from the community sectors identified in the table below. At a minimum, this PHAC shall provide an advisory role to the contractor and, where applicable, all subcontractors to assure the delivery of the services funded through this agreement.

1.4.2. The PHAC membership should be inclusive of all local agencies that provide public health services in the region beyond those funded under this agreement. The purpose is to facilitate improvements in the delivery of the 10 Essential Public Health Services including preparedness-related services and oversight of substance misuse through the continuum of care (prevention, intervention, treatment and recovery) as appropriate to the region. This is accomplished by establishing regional public health priorities that are based on assessments of community health; advocating for the implementation of programs, practices and policies that are evidence-informed to meet improved health outcomes; and advance the coordination of services among partners.

1.4.3. As federal funders, both the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration have developed lists of key community sectors. While described in different ways, the two lists encompass the same community sectors as evident in this table.

Substance Misuse Prevention and Related Health Promotion	Public Health Preparedness
Community Leadership*	
Local Government Safety and Enforcement	Emergency Management
Health and Medical	Health Care Mental / Behavioral Health
Community and Family Support	Cultural and Faith-based Organizations Housing and Sheltering Senior Services Social Services
Business	Business Media
Education	Education and Child Care

*This CDC sector is defined as leaders with policy and decision-making roles, including elected and appointed public officials, leaders of non-governmental organizations and other community-based organizations. Thus, this sector includes leaders from all of the other sectors in this table.

1.5. Membership

1.5.1. At a minimum, the following entities within the region being served shall be invited to participate in the PHAC in order to achieve a broad-based advisory committee comprised of senior leaders from across sectors and communities. It is expected that the larger PHAC will be supported by committees/workgroups, etc. comprised of professionals with more specific topical and/or function-based expertise.

1.5.2. PHAC General Membership

1. Each municipal and county government
2. Each community hospital
3. Each School Administrative Unit (SAU)
4. Each DPHS-designated community health center
5. Each NH Department of Health and Human Services (DHHS)-designated community mental health center
6. The contractor
7. Representative from each of the following community sectors shall also be invited to participate: business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services.
8. Representatives from other sectors or individual entities should be included as determined by the Regional Public Health Advisory Committee.

1.5.5.1. PHAC Executive/Steering Committee Membership

1.5.5.2. For PHACs that include an executive or steering committee, the Contractor shall strive to ensure representation from the following entities.

1. One municipal and county government

2. One community hospital
3. One School Administrative Unit (SAU)
4. One DPHS-designated community health center
5. One NH Department of Health and Human Services (DHHS)-designated community mental health center
6. The contractor
7. Other business, cultural and faith-based organizations, social services, housing and sheltering, media, and senior services.

1.5.5.3. Representatives from other sectors or individual entities should be included as determined by the Regional Public Health Advisory Committee.

1.6. Perform an advisory function to include:

1.6.1. Collaborate with partners to establish annual priorities to strengthen the capabilities within the region to deliver public health services, including public health emergencies and substance misuse through the continuum of care.

1.6.2. Collaborate with regional partners to collect, analyze and disseminate data about the health of the region.

1.6.2.1. Monitor and disseminate data products and reports to public health system partners in the region in order to inform partners about the health status of the region. Disseminate other reports (ex. Weekly Early Event Detection Report) issued by DHHS as appropriate.

1.6.2.2. Educate partners on the NH WISDOM data repository, in order to build capacity to utilize this system to generate and analyze regional data.

1.6.2.3. Participate in local community health assessments convened by other agencies.

1.6.3. Designate representatives of the PHAC to other local or regional initiatives that are providing public health services, including public health emergencies and substance misuse through the continuum of care.

1.6.4. By September 30, publish the Community Health Improvement Plan (CHIP) started in SFY 15.

1.6.4.1. Disseminate the CHIP to regional partners and seek opportunities to educate the community about CHIP priorities, strategies, and activities.

1.6.5. Implement priorities included in the 2015 CHIP.

1.6.5.1. Provide leadership to implement the priorities and strategies included in the CHIP.

1.6.5.2. Implement specific activities for at least one CHIP priority in addition to public health emergency preparedness and substance misuse prevention.

1.6.5.3. Monitor progress of CHIP implementation and provide an annual report describing programs and activities implemented that address CHIP priorities to regional partners and DHHS.

1.6.6. Maintain a set of operating guidelines/principles or by-laws related to the Regional Public Health Advisory Committee that include:

a) Organizational structure
b) Membership
c) Leadership roles and structure
d) Committee roles and responsibilities
e) Decision-making process
f) Subcommittees or workgroups
g) Documentation and record-keeping
h) Process for reviewing and revising the policies and procedures

1.6.7. Assist in the implementation of the biennial PARTNER survey of the PHAC membership.

1.6.8. Implement the PARTNER survey in SFY 2016.

1.6.8.1. Host at least one meeting to share results from the PARTNER survey with regional partners.

1.6.9. Maintain a webpage related to the PHAC.

1.6.10. Attend semi-annual meetings of PHAC leaders convened by the DHHS. Attendees should include a representative of the Contractor and at least one PHAC member.

1.6.11. The chair of the PHAC or their designee should be present at site visits conducted by the NH DPHS and BDAS and, to the extent possible, be available for other meetings as requested.

1.7. Substance Use Disorders, Resiliency and Recovery-Oriented Systems of Care

1.7.1. Development of organizational structures needed within each of the Regional Public Health Networks to study and develop capacity for a seamless substance misuse continuum of care approach that includes: environmental strategies, prevention, early intervention, treatment and recovery support services. Activities will include training, education, and orientation for Public Health Advisory Councils in substance misuse and the progression of substance use disorders and its effect on individuals, families, and communities, including financial impact. This work will include outlining a comprehensive approach to address the misuse of alcohol and drugs within a Resiliency and Recovery Oriented System of Care context.

1.7.2. Building on information from the Regional Continuum of Care Roundtables, and using local expertise as much as possible, the Contractor will develop and implement a work plan to:

1.7.2.1. Recruit and convene subject matter experts, consisting of local healthcare providers and other professionals within the continuum of services to form a workgroup who will help plan, implement and facilitate these deliverables within Resiliency and Recovery Oriented Systems to educate the Public Health Advisory Council about an integrated/collaborative continuum of care Substance Use Disorder strategies and services.

1.7.2.2. Provide education, training and information to Public Health Advisory Council on the impact of the misuse of alcohol and drugs to help members:

1.7.2.2.1. Understand the nature of substance use disorders;

1.7.2.2.2. Learn about the impact of substance use disorders on individuals, families and communities;

1.7.2.2.3. Increase their knowledge of the financial impact of substance use disorders – at the state level, community level, and community sector level;

1.7.2.2.4. Understand the relationship between, and integration of, healthcare and behavioral health, and its relationship to misuse of substances and substance use disorders;

1.7.2.2.5. Learn about the components of Resiliency and Recovery Oriented Systems of Care what they do, and the interrelationship with: Environmental strategies, Prevention services, Intervention services, Treatment services, Recovery support services

1.7.2.3. Discover, understand and envision a comprehensive approach to preventing, treating and recovering from substance use disorders.

1.7.2.4. Connect with and recruit representatives from Community Health Centers, hospital networks and local primary care so that they can provide information to the Public Health Advisory Council on the integration of healthcare and behavioral health, e.g. Screening and Brief Intervention and Referral to Treatment and other evidenced informed practices.

1.7.2.5. Work with Substance Misuse Prevention Coordinator and local prevention coalitions to present information on prevention to the Public Health Advisory Council and the role prevention plays in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.6. Connect with and recruit representatives from intervention/treatment providers to provide information on treatment to the Public Health Advisory Council, and the role intervention/treatment plays in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.7. Connect with and recruit representatives from the recovery community to provide information on recovery and recovery supports to the Public Health

Advisory Councils, and the role recovery supports play in the continuum of services and Resiliency and Recovery Oriented Systems of Care.

1.7.2.8. Familiarize the Public Health Advisory Council with the "Misuse of Alcohol and Drugs" section of the State Health Improvement Plan to prepare them for the development of the Community Health Improvement Plan described in the section above.

1.7.2.9. The Center for Excellence, a technical assistance contractor to the Bureau of Drug and Alcohol Services, will provide materials and host a webinar on elements of a comprehensive system in environmental strategies, prevention, intervention, treatment, and recovery from substance use disorders.

1.8. Substance Misuse Prevention (SMP) and Related Health Promotion

1.8.1. Maintain and/or hire a full-time-equivalent coordinator(s) to manage the project with one person serving as the primary point of contact and management of the scope of work.

1.8.1.1. The Prevention Coordinator(s) is required to be a Certified Prevention Specialist (CPS) or pending certification within one year of start of contract and a graduate from a four year university.

1.8.1.2. Provide or facilitate appropriate professional office space, meeting space, and access to office equipment to conduct the business of the Regional Public Health Network (RPHN).

1.8.1.3. Ensure proper and regular supervision to the Coordinator(s) in meeting the deliverables of this contract.

1.8.2. Ensure the continuance of a committee to serve as the content experts for Substance Misuse Prevention and Related Health Promotion and associated consequences for the region that is under the guidance of and informs the Regional Public Health Advisory Council.

1.8.2.1. The expert committee shall consist of the six sectors, Drug Free Coalitions, Student Assistance Counselors and other grass roots coalitions' representation of the region with a shared focus on substance misuse prevention, the associated consequences and health promotion.

1.8.2.2. The committee will inform and guide regional efforts to ensure priorities and programs are not duplicative but rather build local capacity that is data-driven, evidence-informed, and culturally appropriate to achieve positive outcomes.

1.8.2.3. Ensure the expert committee provides unbiased input into regional activities and development, guidance in the implementation of the strategic plan.

1.8.2.4. Portion of the committee or a member serves as the liaison to the Regional Public Health Advisory Committee.

1.8.3. Attend, assist and participate with the Continuum of Care facilitator and the Continuum of Care work group in the regions' capacity development in continuum of care services.

1.8.4. Develop and implement substance misuse prevention three-year regional strategic plan.

1.8.4.1. Current one-year work plan is good through to Sept 29, 2015 and is available at: http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm.

1.8.4.2. Three-year strategic plan due by September 30, 2015 that is aligned with the Collective Action and Collective Impact Plan http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf, and the State Health Improvement Plan (SHIP) http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf and the region's Community Health Improvement Plan (CHIP).

1.8.4.3. Regional strategic plan needs to be endorsed by expert committee and approved by the PHAC prior to submission to BDAS for approval. PHAC letter of approval is due at the time of submission.

1.8.4.4. Three-year plan needs to be approved by BDAS prior to implementation.

1.8.5. All programs and practices need to be evidenced-informed approaches for substance misuse prevention as outlined in the following document: http://www.dhhs.nh.gov/dcbcs/bdas/documents/evidenceinformedpx.pdf.

1.8.6. Maintain effective training and on-going communication within the Regional Public Health Network, expert committee, PHAC, broader membership, and all subcommittees. Promote the regions substance misuse prevention strategic plans' goals, objectives, activities and outcomes promoted through media and other community information channels and other prevention entities as appropriate.

1.8.7. Utilization of the Strategic Prevention Framework (SPF) five-step planning process to guide regions/communities in the data driven planning process planning, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities http://www.samhsa.gov/spf.

1.8.8. Substance misuse prevention plans and regional efforts need to adhere to the Federal Substance Abuse Prevention and Treatment Block Grant requirements:

1.8.8.1. Prevention approaches must target primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment.

1.8.8.2. Comprehensive primary prevention program shall include activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to the Center for Substance Abuse Prevention categories: Information Dissemination, Education,

Alternatives, Problem Identification and Referral, Community-based Process, and Environmental.

1.8.8.3. A comprehensive approach using the above categories targeting populations with different levels of risk classified by the Institute of Medicine Model: Universal, Selective, and Indicated.

1.8.8.4. All the above information in more detail is outlined under the heading Primary Prevention: http://www.samhsa.gov/grants/block-grants/sabg.

1.8.8.5. Assist the state in meeting the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) through data collection, evaluation and process measures via the PWITS online data system. These regulatory requirements are described and posted on the BDAS website: http://www.dhhs.nh.gov/dcbcs/bdas/documents/bg-px-noms.pdf

1.8.9. Cooperate with and coordinate all evaluation efforts as required by BDAS and DPHS as conducted by the Center for Excellence (e.g. PARTNER Survey, SMP stakeholder survey and all other surveys as directed by BDAS).

1.8.10. Attend all State required trainings, workshops, and bi-monthly meetings and ongoing quality improvement as required demonstrated by attendance and participation with Center for Excellence technical assistance events and learning collaborative(s).

1.8.11. Must respond to BDAS and DPHS emails and inquiry's within 3 to 5 business days or time stated.

1.8.12. Must cooperate with all BDAS site visits as required; at minimum one annually.

1.8.13. Work with BDAS and the Bureau of Liquor Enforcement to institute Comprehensive Synar Plan activities (merchant and community education efforts, youth involvement, policy and advocacy efforts, and other activities). http://www.samhsa.gov/synar.

1.8.14. Coordinate with your RPHN contract administrator in the development and the ongoing maintenance of a Substance Misuse Prevention and Health Promotion website with links to drugfreenh.org and Bureau of Drug and Alcohol Services.

1.8.15. Assist with other State activities as required by BDAS or DPHS.

1.9. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

1.9.1. The Public Health Advisory Council (PHAC) will provide support for the development of regional capacity for a comprehensive, accessible continuum of care for substance use disorder that supports the state plan recommendations, best practice and Department of Health and Human Services priorities. A

comprehensive service array will include developing needed capacity for environmental strategies, prevention, early intervention, treatment and recovery support services. The PHAC will promote the utilization of a Resiliency and Recovery-Oriented System of Care – RROSC (whole person) construct in an effort to minimize the prevalence and consequence of substance misuse in each region. RROSC is a coordinated effort that supports person-centered approach that builds on the strengths and resiliencies of individuals, families, and communities (http://www.dhhs.nh.gov/dcbcs/bdas/index.htm). The work will include:

1.9.1.1. Participation in ongoing education on comprehensive approaches to addressing substance misuse through the development of a regional continuum of care.

1.9.2. Hiring and providing support for one (1) dedicated full-time Continuum of Care (CC) Facilitator to:

1.9.2.1. Be trained in the evidence-based Strategic Planning Model (five steps: Assessment, capacity, develop a plan, Implement the plan, evaluation), Resiliency and Recovery-Oriented System of Care tenants, and NH Comprehensive Systems of Care

1.9.2.2. Ongoing attendance and participation in Regional PHAC meetings and planning.

1.9.2.3. Use the Strategic Planning Model to assess services availability within the continuum of care: prevention, intervention, treatment and recovery support services, including the regions' current assets and capacity for regional level services.

1.9.2.4. Assessment of substance use disorder service within the NH Health Improvement Plan benefits.

1.9.2.5. Work with partners to establish a plan, based on the assessment, to address the gaps and build the capacity to increase substance use disorder services across the continuum.

1.9.2.6. Develop mechanism to coordinate efforts between key Prevention, Intervention, Treatment and Recovery stakeholders.

1.9.2.7. Reconvene or recruit subject matter experts consisting of local (when possible) healthcare providers and other professionals within the continuum of services to form the CC workgroup to assist, coordinate efforts.

1.9.2.8. Develop a plan for communication and for respective roles and responsibilities of the continuum of care workgroup.

1.9.2.9. Work with BDAS and its technical assistance partners to address education, training and technical assistance needs.

1.9.2.10. Recruiting representatives from community health centers, community mental centers, hospitals, primary care, and other health and social service providers to help further efforts in the integration of healthcare and behavioral health by:

1. Promoting substance use screenings at sites at appropriate locations;
2. Providing information on substance misuse trainings available for healthcare and other behavioral health providers;
3. Communicating resources available to address substance misuse issues.

1.9.2.11. Assisting in the continuation or development of a Continuum of Care work group that includes local expertise in:

1. Prevention:Work with the Substance Misuse Coordinator and prevention providers to identify assets, address areas of need and increase access to prevention services;Coordinates this work with the regional three-year strategic prevention plan (available at: https://www.dhhs.nh.gov.bdas/prevention.htm).
2. Intervention/Treatment:Work with Intervention and treatment providers to identify assets, address areas of need and increase capacity and to improved access to services;To develop and maintain established quality standards.
3. Recovery:Work with recovery service providers, including peer led organizations, to identify assets, address areas of need and increase access to services.Work with recovery service providers to enhance or increase services, and/or develop new services.
4. Primary Healthcare/Behavioral Health:Work with primary healthcare providers and behavioral health providers to develop means of integrating substance misuse services, mental health and primary care services within the region, including health promotion.Work with healthcare and behavioral health providers to enhance or increase substance misuse screening other services, and/or develop new services.
5. Based on the work above, develop a format that tracks and makes available information on Prevention, Intervention, Treatment and Recovery resources.

1.9.2.12. Participation with all trainings, technical assistance and evaluations as directed by BDAS

1.10. Staffing Requirements

1.10.1. CONTINUUM OF CARE FACILIATATOR – dedicated full time position

1.10.1.1. This position works with the RPHN and communities to ensure that all necessary partners for the development of a comprehensive continuum of care as described above, and that aligns with the regional Community Health Improvement Plan. These partners should include substance use Prevention, Intervention, Treatment, and Recovery providers, healthcare and behavioral health providers, and other interested or affected parties. The Continuum of Care facilitator will work with BDAS and its technical assistance resources to ensure that all partners have access to information, training and/or technical assistance necessary for them to understand and fully participate in continuum of care development discussions and planning.

1.10.1.2. Qualifications:

1. MPH with focus on systems development or,
2. MSW with focus or experience in macro social work or,
3. Master's degree in Community Development/Organizing or,
4. BA in the any of the above with 2-3 years' experience in public health systems development, macro social work, or community development/organizing.

1.11. Regional Public Health Preparedness

1.11.1. Regional Public Health Emergency Planning

1.11.1.1. The goal of these activities is to provide leadership and coordination to improve the readiness of regional, county, and local partners to mount an effective response to public health emergencies and threats. This will be achieved by conducting a broad range of specific public health preparedness activities to make progress toward meeting the national standards described in the U.S. Centers for Disease Control and Prevention's (CDC) Public Health Preparedness Capabilities (March 2011). All activities shall build on current efforts and accomplishments within the region. All revisions to the regional preparedness annex and appendices, as well as exercises conducted under this agreement will prioritize the building and integration of the resource elements described in the Capabilities Standards.

1.11.1.2. In collaboration with the PHAC described in Section 3.1, provide leadership to further develop, exercise and update the current Regional Public Health Emergency Annex (RPHEA) and related appendices. The RPHEA is intended to serve as an annex or addendum to municipal emergency operations plans to activate a regional response to large-scale public health emergencies. The annex describes critical operational functions and what entities are responsible for carrying them out. The regional annex clearly describe the policies, processes, roles, and responsibilities that municipalities and partner agencies carry out before, during, and after any public health emergency. For more information about the format and structure of emergency plans go to: https://www.fema.gov/media-library/assets/documents/25975.

1.11.1.3. As requested by the DPHS, participate in review of the RPHEA and, related appendices and attachments. Revise and update the RPHEA, related appendices and attachments based on the findings from the review.

1.11.1.4. Participate in an annual Medical Countermeasure Operational Readiness Review (MCM ORR) as required by the CDC Division of Strategic National Stockpile (DSNS). The MCM ORR outlines planning elements specific to managing, distributing and dispensing Strategic National Stockpile (SNS) materiel received from the CDC during a public health emergency. Revise and update the RPHEA, related appendices and attachments based on the findings from the MCM ORR.

1.11.1.5. Develop new incident-specific appendices based on priorities identified by the NH DPHS. The DPHS will provide planning templates and guidance for use by the contractor.

1.11.1.6. Submit the RPHEA and all related appendices and attachments to the NH DPHS by June 30 of each year. Submission shall be in the form of a single hard copy and by posting all materials on E-Studio. E-Studio is a web-based document sharing system maintained by the DPHS.

1.11.1.7. Disseminate the RPHEA and related materials to planning and response partners, including municipal officials from each municipality in the region. Dissemination may be through hard copy or electronic means.

1.11.1.8. Collaborate with hospitals receiving funds under the U. S. DHHS' Hospital Preparedness Program (HPP) cooperative agreement to strengthen and maintain a healthcare coalition in accordance with the "Healthcare Preparedness Capabilities-National Guidance for Healthcare System Preparedness." Healthcare coalitions consist of a collaborative network of healthcare organizations and their respective public and private sector response partners. Healthcare coalitions serve as a multi-agency coordinating group that assists local Emergency Management and Emergency Support Function (ESF) #8 with preparedness, response, recovery and mitigation activities related to healthcare organization disaster operations.[1]

1.11.1.9. Collaborate with municipal emergency management directors to integrate the assets and capabilities included in the RPHEA into municipal and regional shelter plans.

1.11.1.10. Pursue Memorandums of Understanding (MOUs) with governmental, public health, and health care entities that describe the respective roles and responsibilities of the parties in the planning and response to a public health emergency.

[1] Healthcare Preparedness Capabilities-National Guidance for Healthcare System Preparedness. U.S. Department of Health and Human Services, January 2012.

1.11.1.11. Implement at least one priority intervention identified during the regional Hazard Vulnerability Assessment.

1.12. Regional Public Health Emergency Response Readiness

1.12.1. Engage with community organizations to foster connections that assure public health, medical and behavioral health services in the region before, during and after an incident.

1.12.2. Through the Public Health Advisory Committee, continue to collaborate with community organizations to improve the capacity within the region to deliver the Ten Essential Public Health Services.

1.12.3. Improve the capacity and capability within the region to respond to emergencies when requested by the NH DHHS or local governments.

1.12.4. Coordinate the procurement, rotation and storage of supplies necessary for the initial activation of Alternate Care Sites (ACS), Neighborhood Emergency Help Centers (NEHCs) and Points of Dispensing (POD) and support public health, health care and behavioral health services in emergency shelters located within the region.

1.12.5. As needed, develop and execute MOUs with agencies to store, inventory, and rotate these supplies.

1.12.6. Enter and maintain data about the region's response supplies in the Inventory Resources Management System (IRMS) administered by the NH DHHS Emergency Services Unit (ESU) in order to track and manage medical and administrative supplies owned by the contractor.

1.12.7. An inventory of regional supplies shall be conducted at least annually and after every deployment of these supplies. Each agency funded under this agreement will be granted administrative access rights to this web-based system in order to complete this activity.

1.12.8. Disseminate information about, and link appropriate public health and health care professionals with, the NHResponds to allow for the timely activation of volunteers during emergency events. For more information about NHResponds go to: (https://www.nhresponds.org/nhhome.aspx).

1.12.9. Disseminate information about the NH Health Alert Network (HAN) and refer appropriate individuals interested in enrolling to the DPHS HAN coordinator. The HAN is an alerting and notification system administered by the NH DPHS. Receive, and act on as necessary, HAN notices from the DPHS to ensure local partners remain aware of recommendations and guidance issued by the DPHS.

1.12.10. Improve capacity to receive and expend funds associated with public health emergency response in a timely manner. Assess the agency's financial, personnel, and procurement/contract management policies and procedures and

improve procedures to reduce the time needed to receive and use federal and state funds during emergencies.

1.12.11. Sponsor and organize the logistics for at least two trainings/in-services for regional partners. Collaborate with the DHHS, DPHS, the NH Institute of Public Health Practice, the Community Health Institute in Bow, NH, the Preparedness Emergency Response Learning Center at Harvard University and other training providers to implement these training programs. Enter information about training programs and individuals trained into a learning management system administered by NH DPHS to track training programs. In coordination with the DHHS, participate in a Medical Reserve Corps (MRC) within the region or in cooperation with other regions according to guidance from the federal MRC program and the DHHS.

1.12.12. Conduct outreach to health care entities to recruit health care workers with the skills, licensure and credentialing needed to fill positions described in the RPHEA, and related appendices.

1.13. Public Health Emergency Drills and Exercises

1.13.1. Plan and execute drills and exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP).

1.13.2. Maintain a three-year Training and Exercise Plan (TEP) that, at a minimum, includes all drills and exercises as required under the SNS program.

1.13.3. Based on the mutual agreement of all parties and as funding allows, participate in drills and exercises conducted by the NH DPHS, NH DHHS ESU, and NH Homeland Security and Emergency Management (HSEM). AS funding allows, this includes all drills and exercises conducted by NH DHHS to meet CDC requirements for a full-scale exercise regarding medical countermeasures distribution and/or dispensing.

1.13.4. Collaborate with local emergency management directors, hospitals, and public health system partners to seek funding to support other workshops, drills and exercises that evaluate the Capabilities Standards based on priorities established by regional partners.

1.13.5. To the extent possible, participate in workshops, drills and exercises as requested by local emergency management directors or other public health partners.

2. Performance Measures

2.1. Regional Public Health Advisory Committee

2.1.1. Representation of at least 70% of the 11 community sectors identified in the CDC Capabilities Standards that participate in the Regional Public Health Advisory Committee.

2.1.2. Representation of 65% of the 6 community sectors identified in the Governor's Commission plan that participate in the Regional Public Health Advisory Committee.

2.1.3. Documented organizational structure for the Regional Public Health Advisory Committee (e.g. vision or mission statements, organizational charts, MOUs, minutes, etc.).

2.1.4. Establish and increase over time regional connectivity among stakeholders and improved trust among partners via the biennial PARTNER Survey.

2.2. Substance Use Disorders, Resiliency and Recovery – Orientated Systems of Care

2.2.5. Number of subject matter experts from across the Continuum of Care Services recruited and serving on the workgroup.

2.2.6. Number of educational resources developed to educate the PHAC.

2.2.7. Number of educational events identified by the delivery modality (face to face meeting, webinars, etc.) to educate the PHAC.

2.2.8. Number of PHAC members educated.

2.2.9. Submission of PHAC endorsed statement/vision on what constitutes a substance use disorder comprehensive approach for your region's system of care.

2.3. Substance Misuse Prevention and Related Health Promotion

2.3.5. Completion of 3 year substance misuse prevention plan and endorsed by Regional Public Health Advisory Committee and approved by BDAS due September 30, 2015.

2.3.6. Completed an approved annual workplan reflective of new strategic plan due October 31, 2015.

2.3.7. Completed monthly PWITS data entries due by the 20th business day of the following month (e.g. September data due by October 30).

2.3.8. Data entry needs to align with the 3 year strategic plan for substance misuse prevention and health promotion and adhere to the PWITS Policy Guidance document

2.3.9. Host at minimum 4 SMP expert team meetings annually

2.3.10. Meet all Federal regulatory reporting requirements of the Substance Abuse Prevention and Treatment Block Grant.

2.3.11. Participates and coordinates evaluation surveys: SMP stakeholder survey and other surveys as required.

2.3.12. Participates and coordinates attendees and prepare for BDAS or DPHS site visits. At request of the state you may be asked to convene: SMP coordinator, Contract administrator, financial agent, expert team chair and others as requested.

2.3.13. Attendance at SMP bi monthly meetings jointly convened by BDAS and NH Charitable Foundation.

2.3.14. Maintain a SMP website with links to drugfreenh.org and Bureau of Drug and Alcohol Services.

2.3.15. Provides additional information to BDAS when requested.

2.4. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

2.4.5. One full time dedicated Continuum of Care (CC) facilitator hired and completed all required trainings.

2.4.1.1. CC facilitator establishes and convenes the Continuum of Care (CC) workgroup from across the continuum of care, that includes participants from prevention, intervention, treatment and recovery. Includes Healthcare and primary care providers and behavioral health.

2.4.1.2. Submission of meeting minutes including detailed conversations and action items, CC workgroup attendance,

2.4.1.3. Submission of an assessment of regional continuum CC assets, gaps and barriers to service within nine (9) months of the approved contact to include:

2.4.1.3.1. Identification of gaps in CC components and services that need to be developed or enhanced.

2.4.1.3.2. Identification of barriers to cooperation between CC components.

2.4.1.3.3. Identification of barriers to community/client access to component services.

2.4.1.4. Submission of a plan within one (1) year of the approved contract that identifies actions to address issues in the assessment of regional continuum assets, gaps and barriers to services. workplan outlining the activities to be implemented to resolve any barriers and increase capacity of services within the region

2.5. Regional Public Health Preparedness

2.5.5. Score assigned to the region's capacity to dispense medications to the population based on the CDC MCM ORR.

2.5.6. Number of outreach events with entities that employ health care personnel.

2.5.7. Submission of the RPHEA annually

3. Training and Technical Assistance Requirements

3.1. The contractor will participate in training and technical assistance programs offered to agencies receiving funds under this agreement.

3.2. Regional Public Health Preparedness

3.2.1. Participate in bi-monthly Preparedness Coordinator technical assistance meetings.

3.2.2. Develop and implement a technical assistance plan for the region, in collaboration with the agency that is under contract with the NH DPHS to provide that technical assistance.

3.2.3. Complete the training standards recommended for Preparedness Coordinators

3.2.4. Attend the annual Statewide Preparedness Conferences in June 2016 and 2017.

3.3. Medical Reserve Corps

3.3.1. Participate in the development of a statewide technical assistance plan for MRC units.

3.4. Substance Misuse Prevention and Related Health Promotion

3.4.1. Participate in bi month SMP meetings

3.4.2. Maintain Prevention Certification credentialing

3.4.3. Ongoing quality improvement is required as demonstrated by attendance and participation with Center for Excellence on or off site technical assistance and trainings.

3.5. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Continuum of Care.

3.5.1. Ongoing quality improvement is required by attendance and participation in on or offsite technical assistance and trainings provided by the Center for Excellence and/or BDAS staff.

4. Cultural Considerations

4.1. The Contractor shall submit a detailed description of the language assistance services they will provide to persons with Limited English Proficiency to ensure meaningful access to their programs and/or services, within ten (10) days of the effective date of this contract.

5. Administration and Management – All Services

5.1. Workplan

5.1.1. Monitor progress on the final workplans approved by the DHHS. There must be a separate workplan for each of the following based on the services being funded:

5.1.1.1. Regional Public Health Advisory Committee

5.1.1.2. Substance Misuse Prevention and Related Health Promotion

5.1.1.3. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional Resiliency and Recovery Oriented Systems of Care

5.1.1.4. Regional Public Health Emergency Preparedness

5.2. Reporting, Contract Monitoring and Performance Evaluation Activities

5.2.1. Participate in an annual or semi-annual site visit with DHHS, DPHS and BDAS staff. Site visits will include:

5.2.1.1. A review of the progress made toward meeting the deliverables and requirements described in this Exhibit A based on an evaluation plan that includes performance measures.

5.2.1.2. Subcontractors must attend all site visits as requested by DHHS.

5.2.1.3. A financial audit in accordance with state and federal requirements.

5.2.1. Maintain the capability to accept and expend funds to support funded services.

5.2.1.1. Submit monthly invoices within 20 working days after the end of each calendar month in accordance with the terms described in Exhibit B, paragraph 3, on forms provided by the DHHS.

5.2.1.2. Assess agency policies and procedures to determine areas to improve the ability to expedite the acceptance and expenditure of funds during public health emergencies.

5.2.1.3. Assess the agency's capacity to apply for state and federal reimbursement for costs incurred during declared emergencies.

5.2.2. Ensure the capacity to accept and expend new state or federal funds during the contract period for public health and substance misuse prevention and related health promotion services.

5.2.3. Submit for approval all educational materials developed with these funds. Such materials must be submitted prior to printing or dissemination by other means. Acknowledgement of the funding source shall be in compliance with the terms described in this contract.

5.2.4. Provide other programmatic updates as requested by the DHHS.

5.2.5. Engage the Regional Public Health Advisory Committee to provide input about how the contractor can meet its overall obligations and responsibilities under this Scope of Services.

5.2.6.1. Provide the Regional Public Health Advisory Committee with information about public health and substance misuse prevention and related health promotion issues in the state and region that may impact the health and wellness of the public and the ability of communities to respond to and recover from emergencies.

5.2.6.2. Facilitate awareness of the Regional Public Health Advisory Committee about the agency's performance under this Scope of Services by allowing a representative from the Regional Public Health Advisory Committee to participate in site visits and other meetings with the NH DHHS related to the activities being conducted under this agreement.

5.3. Public Health Advisory Committee and Public Health Preparedness

5.3.1. Submit quarterly progress reports based on performance using reporting tools developed by the DPHS.

5.3.2. As requested by the DPHS, complete membership assessments to meet CDC and Assistant Secretary for Preparedness and Response (ASPR) requirements.

5.4. Substance Misuse Prevention and Related Health Promotion

5.4.1. Complete monthly data entry in the BDAS P-WITS system that aligns and supports the regional substance misuse prevention and related health promotion plan.

5.4.2. Contractor will submit the following to the State:

5.4.2.1. Submit updated or revised strategic plans for approval prior to implementation.

5.4.2.2. Submit annual report to BDAS due June 25, 2016 and 2017 (template and guidance will be provided by CEFx).

5.4.2.3. Cooperate and coordinate all evaluation efforts conducted by the Center for Excellence, (e.g. Stakeholder Survey, annual environmental measure, and other surveys as directed by BDAS).

5.4.3. Participate in an annual or semi-annual site visit with DHHS, DPHS and BDAS staff. Site visits will include:

5.4.4. A review of the progress made toward meeting the deliverables and requirements described in this Exhibit A based on an evaluation plan that includes performance measures.

5.4.4.1. Subcontractors must attend all site visits as requested by DHHS.

5.4.5. A financial audit in accordance with state and federal requirements.

5.4.6. Provide additional information as a required by BDAS.

5.5. Comprehensive Approach to Addressing Substance Misuse through the Continued Development of a Regional

5.5.1. Contractor will submit the following to the State:

5.5.1.1. Quarterly reports (dates for submission and template will be provided by BDAS).

5.5.1.2. Report on prevention, intervention, treatment and recovery services gap assessment within nine (9) months of the date of contract.

5.5.1.3. Plan to address gaps in services identified within twelve (12) months of the date of contract.

Exhibit B

Method and Conditions Precedent to Payment

1) Funding Sources:

a. $330,760 = 100% federal funds from the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.959, Federal Award Identification Number (FAIN), TI010035-14, Account # 05-95-49-491510-2988-102-500731, $165,380 in SFY 2016 and $165,380 in SFY 2017.

b. $30,000 = 100% federal funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.758, Federal Award Identification Number (FAIN), B01OT009037, Account # 05-95-90-901010-5362-102-500731, $15,000 in SFY 2016 and $15,000 in SFY 2017.

c. $104,542 = 85.45% federal funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.074, Federal Award Identification Number (FAIN), U90TP000535, and 14.55% general funds, Account # 05-95-90-902510-7545-102-500731, $52,271 in SFY 2016 and $52,271 in SFY 2017.

d. $67,600 = 100% federal funds from the US Department of Health and Human Services, Centers for Disease Control and Prevention, CFDA #93.074, Federal Award Identification Number (FAIN), U90TP000535, Account # 05-95-90-902510-7545-102-500731, $33,800 in SFY 2016 and $33,800 in SFY 2017.

$532,902 Total

2) The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.

a. Payment for said services shall be made as follows:

The Contractor will submit an invoice in a form satisfactory to the State by the twentieth working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. The final invoice shall be due to the State no later than forty (40) days after the contract Completion Date.

b. The invoice must be submitted to:

Department of Health and Human Services
Division of Public Health Services
Email address: DPHScontractbilling@dhhs.state.nh.us

Exhibit B

3) This is a cost-reimbursement contract. The Contractor agrees to use and apply all contract funds from the State for direct and indirect costs and expenses including, but not limited to, personnel costs and operating expenses related to the Services, as detailed in Exhibit B-1 – SFY 2016 and SFY 2017 Budgets, and reimbursement shall be made monthly based on actual costs incurred during the previous month. Allowable costs and expenses shall be determined by the State in accordance with applicable state and federal laws and regulations. The Contractor agrees not to use or apply such funds for capital additions or improvements, entertainment costs, or any other costs not approved by the State. DHHS funding may not be used to replace funding for a program already funded from another source.

4) Payment will be made by the State agency subsequent to approval of the submitted invoice and if sufficient funds are available in the Service category budget line items submitted by the Contractor to cover the costs and expenses incurred upon compliance with reporting requirements and performance and utilization review. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.

5) Contractors are accountable to meet the scope of services. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding. Corrective action may include actions such as a contract amendment or termination of the contract. The contracted organization shall prepare progress reports, as required.

6) The Contractor shall have written authorization from the State prior to using contract funds to purchase any equipment with a cost in excess of three hundred dollars ($300) and with a useful life beyond one year.

7) Notwithstanding paragraph 18 of the General Provisions P-37, an amendment limited to adjustments to amounts between and among account numbers and Exhibit B-1 Budgets, within the price limitation, and to adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1 Budget Form (SFY 2016)

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: LAMPREY HEALTH CARE, INC.

Budget Request for: NH Regional Public Health Network Services
(Name of RFP)

Budget Period: SFY 2016

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 178,013.00	$ -	$ 178,013.00	
2. Employee Benefits	$ 40,497.96	$ -	$ 40,497.96	
3. Consultants	$ -	$ -	$ -	
4. Equipment:	$ 2,900.00	$ -	$ 2,900.00	
Rental	$ -	$ -	$ -	
Repair and Maintenance	$ 200.00	$ -	$ 200.00	
Purchase/Depreciation	$ -	$ -	$ -	
5. Supplies:	$ -	$ -	$ -	
Educational	$ 250.00	$ -	$ 250.00	
Lab	$ -	$ -	$ -	
Pharmacy	$ -	$ -	$ -	
Medical	$ -	$ -	$ -	
Office	$ 1,536.35	$ -	$ 1,536.35	
6. Travel	$ 5,210.00	$ -	$ 5,210.00	
7. Occupancy	$ -	$ -	$ -	
8. Current Expenses	$ -	$ -	$ -	
Telephone	$ 3,422.00	$ -	$ 3,422.00	
Postage	$ 190.00	$ -	$ 190.00	
Subscriptions	$ 650.00	$ -	$ 650.00	
Audit and Legal	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	
Board Expenses	$ 1,200.00	$ -	$ 1,200.00	
9. Software	$ 150.00	$ -	$ 150.00	
10. Marketing/Communications	$ 1,200.00	$ -	$ 1,200.00	
11. Staff Education and Training	$ 3,307.44	$ -	$ 3,307.44	
12. Subcontracts- Community Readin	$ 3,000.00	$ -	$ 3,000.00	
12. Subcontracts- Suicide Prevention	$ 470.35	$ -	$ 470.35	
13. Other (specific details mandatory)	$ -	$ -	$ -	
		$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ 24,253.91	$ 24,253.91	
TOTAL	**$ 242,197.10**	**$ 24,253.91**	**$ 266,451.00**	

Indirect As A Percent of Direct 10.0%

Exhibit B-1 Budget Form (SFY 2017)

New Hampshire Department of Health and Human Services

Bidder/Contractor Name: LAMPREY HEALTH CARE, INC.

Budget Request for: NH Regional Public Health Network Services
(Name of RFP)

Budget Period: SFY 2017

Line Item	Direct Incremental	Indirect Fixed	Total	Allocation Method for Indirect/Fixed Cost
1. Total Salary/Wages	$ 181,573.26	$ -	$ 181,573.26	
2. Employee Benefits	$ 41,307.92	$ -	$ 41,307.92	
3. Consultants	$ -	$ -	$ -	
4. Equipment:	$ -	$ -	$ -	
Rental	$ -	$ -	$ -	
Repair and Maintenance	$ 200.00	$ -	$ 200.00	
Purchase/Depreciation	$ -	$ -	$ -	
5. Supplies:	$ -	$ -	$ -	
Educational	$ 250.00	$ -	$ 250.00	
Lab	$ -	$ -	$ -	
Pharmacy	$ -	$ -	$ -	
Medical	$ -	$ -	$ -	
Office	$ 1,150.00	$ -	$ 1,150.00	
6. Travel	$ 4,710.00	$ -	$ 4,710.00	
7. Occupancy	$ -	$ -	$ -	
8. Current Expenses	$ -	$ -	$ -	
Telephone	$ 2,600.00	$ -	$ 2,600.00	
Postage	$ 190.00	$ -	$ 190.00	
Subscriptions	$ 650.00	$ -	$ 650.00	
Audit and Legal	$ -	$ -	$ -	
Insurance	$ -	$ -	$ -	
Board Expenses	$ 1,300.00	$ -	$ 1,300.00	
9. Software	$ 150.00	$ -	$ 150.00	
10. Marketing/Communications	$ 1,000.00	$ -	$ 1,000.00	
11. Staff Education and Training	$ 3,668.00	$ -	$ 3,668.00	
12. Subcontracts- Community Readin	$ 3,000.00	$ -	$ 3,000.00	
12. Subcontracts- Suicide Prevention		$ -	$ -	
13. Other (computer operation):	$ 479.04	$ -	$ 479.04	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ -	$ -	
	$ -	$ 24,222.78	$ 24,222.78	
TOTAL	**$ 242,228.22**	**$ 24,222.78**	**$ 266,451.00**	

Indirect As A Percent of Direct 10.0%

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

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

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

(a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

(b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

(c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed
19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS
As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

Exhibit C-1

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

   4. CONDITIONAL NATURE OF AGREEMENT.

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

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. Insurance

   Subparagraph 14.1.1 of the General Provisions of this contract is deleted and the following subparagraph is added:

   14.1.1 Comprehensive general liability against all claims of bodily injury, death or property damage, in amounts of not less than $250,000 per claim and $1,000,000 per occurrence and excess umbrella liability coverage in the amount of $1,000,000 per occurrence.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

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

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

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

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

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

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

INSTRUCTIONS FOR CERTIFICATION

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

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

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

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

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

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

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

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

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

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

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

PRIMARY COVERED TRANSACTIONS

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

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

LOWER TIER COVERED TRANSACTIONS

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Obligations and Activities of Business Associate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Obligations of Covered Entity

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

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

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

(5) Termination for Cause

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

(6) Miscellaneous

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

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

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

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

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

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

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

Department of Health and Human Services	Lamprey Health Care
The State	Name of the Contractor
Signature of Authorized Representative	Signature of Authorized Representative
Brook Dupee	Audrey Ashton-Savage
Name of Authorized Representative	Name of Authorized Representative
Bureau Chief	President, Board of Directors
Title of Authorized Representative	Title of Authorized Representative
5/11/15	5/1/15
Date	Date

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

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

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

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

Contractor Name: Lamprey Health Care

5/1/15
Date

A. Ashton-Savage
Name: Audrey Ashton-Savage
Title: President, Board of Directors

FORM A

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

1. The DUNS number for your entity is: 040254401

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

   ✓ NO _____ YES

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

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

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

   _____ NO _____ YES

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

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

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

   Name: _____ Amount: _____

   Name: _____ Amount: _____

   Name: _____ Amount: _____

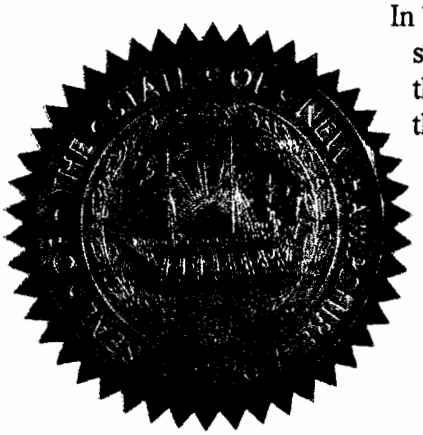
   Name: _____ Amount: _____

   Name: _____ Amount: _____

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 LAMPREY HEALTH CARE, INC. is a New Hampshire nonprofit corporation formed August 16, 1971. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 29th day of April, A.D. 2015

William M. Gardner
Secretary of State

CERTIFICATE OF VOTE

I, Janis Reams, do hereby certify that:
(Name of the elected Officer of the Agency; cannot be contract signatory)

1. I am a duly elected Officer of Lamprey Health Care, Inc.
(Agency Name)

2. The following is a true copy of the resolution duly adopted at a meeting of the Board of Directors of the Agency duly held on April 22, 2015:
(Date)

RESOLVED: That the President
(Title of Contract Signatory)

is hereby authorized on behalf of this Agency to enter into the said contract with the State and to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, as he/she may deem necessary, desirable or appropriate.

3. The forgoing resolutions have not been amended or revoked, and remain in full force and effect as of the 1 day of May, 2015.
(Date Contract Signed)

4. Audrey Ashton - Savage is the duly elected President
(Name of Contract Signatory) (Title of Contract Signatory)

of the Agency.

Janis Reams
(Signature of the Elected Officer)

STATE OF NEW HAMPSHIRE

County of Rockingham

The forgoing instrument was acknowledged before me this 1 day of May, 2015,

By Janis Reams.
(Name of Elected Officer of the Agency)

Anita R. Rozeff
(Notary Public/Justice of the Peace)

(NOTARY SEAL)

Commission Expires: 3/16/16

Anita R. Rozeff, Notary Public

My commission expires March 16, 2016

Client#: 246027 LAMPREYHEA1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 06/18/2014

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

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

PRODUCER	CONTACT NAME: Amanda Keaveney
HUB Healthcare Solutions HUB International New England, LLC 136 Turnpike Road, Suite 105 Southborough, MA 01772	PHONE (A/C, No, Ext): 508-303-9470 FAX (A/C, No): 508-303-9476 E-MAIL ADDRESS: amanda.keaveney@hubinternational.com

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

INSURED
LAMPREY HEALTH CARE, INC.
207 SOUTH MAIN STREET
Newmarket, NH 03857

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			PHPK1191125	07/01/2014	07/01/2015	EACH OCCURRENCE	$1,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$20,000
							PERSONAL & ADV INJURY	$1,000,000
							GENERAL AGGREGATE	$3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$3,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
A	AUTOMOBILE LIABILITY			PHPK1191125	07/01/2014	07/01/2015	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	[X] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS [X] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
A	[X] UMBRELLA LIAB [X] OCCUR			PHUB463239	07/01/2014	07/01/2015	EACH OCCURRENCE	$5,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$5,000,000
	[ ] DED [X] RETENTION $10,000							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N	N/A		WCA00545402	07/01/2014	07/01/2015	[X] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] (Mandatory in NH)						E.L. EACH ACCIDENT	$500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$500,000
							E.L. DISEASE - POLICY LIMIT	$500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Policy contains 60 Days Notice of Cancellation except 10 Days for Non-Payment of Premium.

CERTIFICATE HOLDER

Director
Division of Public Health Services; NH DHHS
29 Hazen Drive
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

LAMPREY HEALTH CARE

Our Mission

The mission of Lamprey Health Care is to provide high quality primary medical care and health related services, with an emphasis on prevention and lifestyle management, to all individuals regardless of ability to pay.

We seek to be **a leader in providing access** to medical and health services that improve the health status of the individuals and families in the communities we serve.

Our mission is to **remove barriers that prevent access to care**; we strive to eliminate such barriers as language, cultural stereotyping, finances and/or lack of transportation.

Lamprey Health Care's **commitment to the community** extends to providing and/or coordinating access to a full range of comprehensive services.

Lamprey Health Care is committed to achieving the highest level of patient satisfaction through a personal and caring approach and **exceeding standards of excellence in quality and service**.

Our Vision

We will be the **outstanding primary care choice** for our patients, our communities and our service area, and the standard by which others are judged.

We will continue as **pacesetter** in the use of new knowledge for lifestyle improvement, quality of life.
We will be a **center of excellence** in service, quality and teaching.

We will be **part of an integrated system** of care to ensure access to medical care for all individuals and families in our communities.

We will be an **innovator** to foster development of the best primary care practices, adoption of the tools of technology and teaching.

We will **establish partnerships**, linkages, networks and referrals with other organizations to provide access to a full range of services to meet our communities' needs.

Our Values

We exist to **serve the needs of our patients**.

We value a positive **caring approach** in delivering patient services.

We are committed to **improving the health** and total well-being of our communities.

We are committed to **being proactive** in identifying and meeting our communities' health care needs.

We provide a supportive environment for **the professional and personal growth, and healthy lifestyles of our employees**.

We provide an **atmosphere of learning** and growth for both patients and employees as well as for those seeking training in primary care.

We succeed by utilizing a **team approach** that values a positive, constructive commitment to Lamprey Health Care's mission.

LAMPREY HEALTH CARE, INC.
AND
FRIENDS OF LAMPREY HEALTH CARE, INC.

AUDITED CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2014 AND 2013

CONTENTS

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditors' Report on Consolidated Financial Statements

Board of Directors
Lamprey Health Care, Inc. and
Friends of Lamprey Health Care, Inc.
Newmarket, New Hampshire

We have audited the accompanying consolidated financial statements of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc., which comprise the balance sheets as of September 30, 2014 and 2013, the related statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc. as of September 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating statements are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating statements are fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated December 23, 2014, on our consideration of the Association's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing the results of our audit.

Concord, New Hampshire
December 23, 2014

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED BALANCE SHEETS

SEPTEMBER 30, 2014 AND 2013

ASSETS

	2014	2013
Current Assets:		
Cash and cash equivalents	$ 1,775,337	$ 2,141,018
Accounts receivable, less allowance for doubtful accounts of $231,834 and $136,707 at September 30, 2014 and 2013, respectively	989,558	697,315
Grants receivable	2,948,605	2,342,884
Other receivables	366,246	285,546
Other current assets	94,731	101,303
Total Current Assets	6,174,477	5,568,066
Assets Limited As To Use	1,946,541	1,983,526
Property And Equipment, Net	8,030,057	8,247,061
TOTAL ASSETS	$ 16,151,075	$ 15,798,653

LIABILITIES AND NET ASSETS

Current Liabilities:		
Accounts payable and accrued expenses	$ 174,455	$ 172,258
Accrued salaries and related expenses	947,248	1,004,995
Due to third party payers	73,250	73,250
Deferred revenue	3,125,597	2,547,702
Current maturities of long-term debt	82,770	106,330
Total Current Liabilities	4,403,320	3,904,535
Long-term Debt, Less Current Maturities	2,527,181	2,738,135
Total Liabilities	6,930,501	6,642,670
Net Assets:		
Unrestricted	8,819,133	8,733,063
Temporarily restricted	401,441	422,920
Total Net Assets	9,220,574	9,155,983
TOTAL LIABILITIES AND NET ASSETS	$ 16,151,075	$ 15,798,653

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF OPERATIONS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Operating Revenue:		
Patient service revenue	$ 7,328,236	$ 6,801,083
Provision for bad debts	(495,147)	(401,602)
Net patient service revenue	6,833,089	6,399,481
Grants, contracts, and contributions, net	4,102,931	3,933,920
Other operating revenue	1,193,248	2,470,950
Net assets released from restriction for operations	8,146	-
Interest income	721	1,879
Total Operating Revenue	12,138,135	12,806,230
Operating Expenses:		
Payroll and related expenses	9,259,609	9,366,421
Other operating expenses	2,296,631	2,495,061
Depreciation	377,986	379,796
Interest expense	128,331	134,376
Total Operating Expenses	12,062,557	12,375,654
OPERATING INCOME AND EXCESS OF REVENUE OVER EXPENSES	$ 75,578	$ 430,576

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Unrestricted Net Assets:		
Excess of revenue over expenses	$ 75,578	$ 430,576
Change in fair value of financial instrument	(2,841)	56,115
Net assets released from restrictions for capital acquisitions	13,333	161,465
Increase in Unrestricted Net Assets	86,070	648,156
Temporarily Restricted Net Assets:		
Contributions	-	68,981
Net assets released from restrictions for operations	(8,146)	-
Net assets released from restrictions for capital acquisitions	(13,333)	(161,465)
Decrease in Temporarily Restricted Net Assets	(21,479)	(92,484)
Change in Net Assets	64,591	555,672
Net assets, beginning of year	9,155,983	8,600,311
NET ASSETS, END OF YEAR	$ 9,220,574	$ 9,155,983

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows From Operating Activities:		
Change in net assets	$ 64,591	$ 555,672
Adjustments to reconcile change in net assets to net cash (used) provided by operating activities:		
Provision for bad debt	495,147	401,602
Depreciation	377,986	379,796
Change in fair value of financial instrument	2,841	(56,115)
Restricted contributions	-	(68,981)
(Increase) decrease in the following assets:		
Patients accounts receivable	(787,390)	(328,009)
Grants receivable	(605,721)	(91,477)
Other receivables	(80,700)	87,224
Other current assets	6,572	8,188
Increase (decrease) in the following liabilities:		
Accounts payable and accrued expenses	2,197	(144,919)
Accrued payroll and related expenses	(57,747)	152,662
Deferred revenue	577,895	90,657
Net Cash (Used) Provided by Operating Activities	(4,329)	986,300
Cash Flows From Investing Activities:		
Decrease (increase) in assets limited as to use	36,985	(370,418)
Capital expenditures	(160,982)	(87,494)
Net Cash Used by Investing Activities	(123,997)	(457,912)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

FOR THE YEARS ENDED SEPTEMBER 30, 2014 AND 2013

	2014	2013
Cash Flows From Financing Activities:		
Restricted contributions	-	68,981
Principal payments on long-term debt	(237,355)	(101,527)
Net Cash Used by Financing Activities	(237,355)	(32,546)
Net (Decrease) Increase in Cash and Cash Equivalents	(365,681)	495,842
Cash and Cash Equivalents, Beginning of Year	2,141,018	1,645,176
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 1,775,337	$ 2,141,018
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 128,331	$ 134,376

(See accompanying notes to these consolidated financial statements)

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

SEPTEMBER 30, 2014 AND 2013

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Lamprey Health Care, Inc. "LHC" is a private non-stock, non-profit corporation organized in New Hampshire. The Organization is a Federally Qualified Health Center (FQHC) whose primary purpose is to provide quality based family health and medical services to residents of Southern New Hampshire without regard to the patient's ability to pay for these services.

Subsidiary

Friends of Lamprey Health Care, Inc. "FLHC" is a non-stock, non-profit corporation organized in New Hampshire. FLHC's primary purpose is to support Lamprey Health Care, Inc. FLHC is also the property owner of LHC's Newmarket administrative and program offices. LHC is the sole member of FLHC.

Principles of Consolidation

The consolidated financial statements include the accounts of LHC and its subsidiary, FLHC. These agencies are collectively referred to as "the Organization." All significant intercompany balances and transactions have been eliminated in consolidation.

Income Taxes

Both LHC and FLHC are public charities under Section 501(c)(3) of the Internal Revenue Code. As public charities, the entities are exempt from state and federal income taxes on income earned in accordance with its tax exempt purpose. Unrelated business income is subject to state and federal income tax. Management has evaluated each entity's tax position and concluded that there is no unrelated business income or uncertain tax positions that require adjustment to the consolidated financial statements. Management believes the Agency is no longer subject to income tax examinations for years prior to 2011.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use. Short-term highly liquid investments with an original maturity of more than three months are classified as temporary investments.

Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization analyzes its past history and identifies trends for all funding sources in the aggregate. In addition, balances in excess of one year are 100% reserved. Management regularly reviews data about revenue and payor mix in evaluating the sufficiency of the allowance for doubtful accounts. Amounts not collected after all reasonable collection efforts have been exhausted are applied against the allowance for doubtful accounts. The Organization has not changed its methodology for estimating the allowance for doubtful accounts during the years ended September 30, 2014 and 2013.

A reconciliation of the allowance for doubtful accounts follows:

	2014	2013
Balance, beginning of year	$ 136,707	$ 133,624
Provision	495,147	401,602
Write-offs	(400,020)	(398,519)
Balance, end of year	$ 231,834	$ 136,707

The increase in in the allowance for doubtful accounts is primarily related to an increase in the age of the accounts receivable balances due to industry wide delays in state reimbursement and certain managed care providers, particularly related to health care reform.

Assets Limited As to Use

Assets limited as to use include assets set aside under loan agreements for repairs and maintenance on the real property collateralizing the loan and assets designated by the board of directors and donor restricted contributions.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property and Equipment

Property and equipment are carried at cost, less accumulated depreciation. Maintenance repairs and minor renewals are expensed as incurred and renewals and betterments are capitalized. Depreciation is computed on the straight-line method and is provided over the estimated useful life of each class of depreciable asset.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets include contribution and grants for which donor-imposed restrictions have not been met. Assets are released from restrictions as expenditures are made in line with restrictions called for under the terms of the donor.

Permanently restricted net assets are restricted by donors to be maintained by the Organization in perpetuity. There were no permanently restricted net assets.

Gifts of Long-lived Assets

Gifts of long-lived assets, such as land, buildings, or equipment, are reported as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets or used to extinguish debt related to long-lived assets, are reported as restricted support. In the absence of explicit donor stipulations about how long those long-lived assets must be maintained, expiration of donor restrictions are reported when the donated, acquired long-lived assets are placed in service, or when gifts of cash are used for the extinguishment of debt related to the long-lived assets.

Patient Service Revenue

The Organization has agreements with third-party payers that provide for payments to the Organization at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

- Medicare -- Primary care services rendered to Medicare program beneficiaries are reimbursed under cost reimbursement methodology. The Organization is reimbursed at a tentative encounter rate with final settlement determined after submission of annual cost reports by the Organization and audits thereof by the Medicare fiscal intermediary. The Organization's Medicare cost reports have been retroactively settled by the Medicare Administrative Contractor through June 30, 2012.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Patient Service Revenue (Continued)

- Other payers -- The Organization also has entered into payment agreements with Medicaid, certain commercial insurance carriers, health maintenance Organizations and preferred provider Organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per visit and discounts from established charges.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs. The Organization believes that it is in substantial compliance with all applicable laws and regulations. However, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term. Differences between amounts previously estimated and amounts subsequently determined to be recoverable or payable are included in other operating revenue in the year that such amounts become known. The Organization recorded a favorable change from prior year third party cost report estimates amounting to $26,724 and $208,822 for the years ended September 30, 2014 and 2013, respectively.

The Organization, as a FQHC, is eligible to participate in the 340B Drug Pricing Program. The program requires drug manufacturers to provide outpatient drugs to FQHC's and other identified entities at a reduced price. The Organization contracts with local pharmacies under this program. The local pharmacies dispense drugs to eligible patients of the Organization and bill Medicare and commercial insurances on behalf of the Organization. Reimbursement received by the pharmacies is remitted to the Organization, less dispensing and administrative fees. Gross revenue generated from the program is included in patient service revenue. Contracted expenses incurred related to the program are included in other operating expenses.

Excess of Revenue Over Expenses

The statement of operations includes excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include the change in fair value of financial instruments and contributions of long-lived assets (including assets acquired using contributions and grants which by donor restriction were to be used for the purposes of acquiring such assets).

NOTE 2 ASSETS LIMITED AS TO USE

Assets limited as to use is composed of cash and cash equivalents and consisted of the following at September 30, 2014 and 2013:

	2014	2013
United States Department of Agriculture:		
Rural Development loan agreements	$ 142,359	$ 167,094
Designated by the governing board:		
Capital	210,000	210,000
Working capital (federal monies)	507,000	507,000
Transportation	26,882	26,882
Ann Peters health care access	6,085	6,085
ICD-10 implementation	796,082	796,082
Donor restricted:		
Temporarily (Note 6)	258,133	270,383
Total	$ 1,946,541	$ 1,983,526

Cash and cash equivalents included in assets limited as to use are not considered cash and cash equivalents for cash flow purposes.

NOTE 3 PROPERTY AND EQUIPMENT

The cost and accumulated depreciation of property and equipment at September 30, 2014 and 2013 follows:

	2014	2013
Land	$ 1,146,784	$ 1,138,520
Building and improvements	10,345,448	10,331,023
Furniture and equipment	1,841,962	1,842,019
Total Cost	13,334,195	13,311,562
Less, accumulated depreciation	5,304,137	5,064,501
Total Property and Equipment, Net	$ 8,030,057	$ 8,247,061

NOTE 3 PROPERTY AND EQUIPMENT (CONTINUED)

In 2011 the Organization made renovations to certain buildings with Federal grant funding under the ARRA - Facility Improvement Program. In accordance with the grant agreement, a Notice of Federal Interest (NFI) is required to be filed in the appropriate official records of the jurisdiction in which the property is located. The NFI is designed to notify any prospective buyer or creditor that the Federal Government has a financial interest in the real property acquired under the aforementioned grant; that the property may not be used for any purpose inconsistent with that authorized by the grant program statute and applicable regulations; that the property may not be mortgaged or otherwise used as collateral without the written permission of the Associate Administrator of the Office of Federal Assistance Management, Health Resources and Services Administration (OFAM, HRSA); and that the property may not be sold or transferred to another party without the written permission of the Associate Administrator of OFAM and HRSA.

NOTE 4 LINE OF CREDIT

The Organization has an available $1,000,000 revolving line of credit from a local bank through May 2016, with an effective interest rate of 3.25%. The line of credit is secured by all business assets. There was no outstanding balance at September 30, 2014 and 2013, respectively.

NOTE 5 LONG-TERM DEBT

A summary of notes payable at September 30, 2014 and 2013 follows:

	2014	2013
Promissory note payable to TD Bank, N.A. See terms outlined below	$ 958,515	$ 973,273
A 4.375% promissory note payable to the Rural Development Organization, paid in monthly installments of $5,000, which includes interest through December 2036. The note is secured by all tangible property owned by the Organization.	850,409	872,676

NOTE 5 LONG-TERM DEBT (CONTINUED)

	2014	2013
A 5.375% promissory note payable to the Rural Development Organization, paid in monthly installments of $4,949, which includes interest through June 2026. The note is secured by real estate owned by the Organization.	516,396	547,142
A 4.75% promissory note payable to the Rural Development Organization, paid in monthly installments of $1,892, which includes interest, through November 2033. The note is secured by real estate owned by the Organization.	284,631	293,610
A 6.00% promissory note payable to the Rural Development Organization, paid in monthly installments of $3,000, which includes interest, through November 2019. The note is secured by real estate owned by the Organization. The note was paid in full in August 2014.	-	157,764
Total Long-term Debt	2,609,951	2,844,465
Less current maturities	82,770	106,330
Long-term Debt Excluding Current Maturities	$ 2,527,181	$ 2,738,135

During 2012, the Organization obtained a $1,000,000 promissory note with TD Bank, N.A. to finance the construction of the medical facility in Nashua, New Hampshire. The note is secured by the real estate. Payments of interest only at 4.25% were due on the note during the construction phase of the note through January 2013, at which time the note converted to a ten year balloon note to be paid at the amortization rate of 30 years with monthly principal payments of $1,345 plus interest at 85% of the one month LIBOR rate plus 2.125% through January 2022 when the balloon payment is due. During 2012, the Organization obtained an interest rate swap agreement for the ten year period that limits the potential rate fluctuation and essentially fixes the rate at 4.13%. The fair market value of the interest rate swap agreement was a liability of $6,405 and $3,563 at September 30, 2014 and 2013, respectively.

NOTE 5 LONG-TERM DEBT (CONTINUED)

New Hampshire Health and Educational Facilities Authority (NH HEFA) is participating in the lending for thirty percent of the promissory note, amounting to $300,000. Under the NH HEFA program, the interest rate on that portion is not subject to the swap agreement and is a variable rate based on 50% of the interest rate charged by the local banking institution, which is 85% of the one month LIBOR rate plus 2.125%.

The Organization is required to meet certain annual minimum covenants as defined in the loan agreement with TD Bank. The covenants were met at September 30, 2014.

Scheduled principal repayments on long-term debt for the next five years and thereafter follows:

September 30,	
2015	$ 82,770
2016	86,453
2017	90,313
2018	94,356
2019	99,144
Thereafter	2,156,915
Total	$ 2,609,951

NOTE 6 TEMPORARILY RESTRICTED NET ASSETS

Temporarily restricted net assets at September 30, 2014 and 2013 follows:

	2014	2013
Temporarily restricted for:		
Diabetes	$ 12,157	$ 20,303
Capital acquisitions	389,284	402,617
Total	$ 401,441	$ 422,920

The composition of temporarily restricted net assets at September 30, 2014 and 2013 follows:

	2014	2013
Assets limited as to use	$ 258,133	$ 270,383
Property and equipment	143,308	152,537
Total	$ 401,441	$ 422,920

NOTE 7 PATIENT SERVICE REVENUE

A summary of patient service revenue for the years ended September 30, 2014 and 2013 follows:

	2014	2013
Medical patient service revenue	$ 7,315,803	$ 6,801,083
340B pharmacy revenue	12,433	-
Total Patient Service Revenue	$ 7,328,236	$ 6,801,083

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, the revenue is recorded net of the free care allowance. The Organization estimates the costs associated with providing charity care by calculating the ratio of total cost to total gross charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to patients eligible for free care. The estimated cost of providing services to patients under the Organization's charity care policy amounted to $1,484,937 and $1,787,696 for the years ended September 30, 2014 and 2013, respectively.

The Organization is able to provide these services with a component of funds received through local community support and federal and state grants. Local community support consists of contributions and United Way and municipal appropriations.

NOTE 8 FUNCTIONAL EXPENSES

The Organization provides various services to residents within its geographic location. Expenses related to providing these services for the years ended September 30, 2014 and 2013 follows:

	2014	2013
Program services	$10,338,279	$10,572,681
Administrative and general	1,724,278	1,802,973
Total	$12,062,557	$12,375,654

NOTE 9 RETIREMENT PLAN

The Organization sponsors a defined contribution plan under Section 403(b) of the Internal Revenue Code. Contributions to the plan amounted to $344,393 and $361,208 for the years ended September 30, 2014 and 2013, respectively.

NOTE 10 CONCENTRATION OF RISK

The Organization has cash deposits in major financial institutions in excess of $250,000, which exceeds federal depository insurance limits. The financial institution has a strong credit rating and management believes the credit risk related to these deposits is minimal. The Organization purchases overnight securities backed by the Federal Government on a daily basis. Funds are re-deposited with interest the following business morning.

At September 30, 2014, Medicare represented 15% and Medicaid represented 29% of gross accounts receivable. No other individual payer source exceeded 10% of the gross accounts receivable balance.

NOTE 11 MALPRACTICE INSURANCE

The Organization is protected from medical malpractice risk as a FQHC under the Federal Tort Claims Act (FTCA). The Organization has additional medical malpractice insurance, on a claims-made basis, for coverage outside the scope of the protection of the FTCA. As of the year ended September 30, 2014, there were no known malpractice claims outstanding which in the opinion of management, will be settled for amounts in excess of both FTCA and medical malpractice insurance coverage; nor are there any unasserted claims or incidents which require loss accrual. The Organization intends to renew medical malpractice insurance coverage on a claims-made basis and anticipates that such coverage will be available.

NOTE 12 SUBSEQUENT EVENTS

For financial reporting purposes, subsequent events have been evaluated by management through December 23, 2014, which is the date the financial statements were available to be issued.

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2014

ASSETS

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Totals
Current Assets:				
Cash and cash equivalents	$ 1,230,606	$ 544,731	$ -	$ 1,775,337
Accounts receivable, net	989,558	-	-	989,558
Grants receivable	2,948,605	-	-	2,948,605
Other receivables	366,246	-	-	366,246
Other current assets	94,731	-	-	94,731
Total Current Assets	5,629,746	544,731	-	6,174,477
Assets Limited As To Use	1,860,197	86,344	-	1,946,541
Property And Equipment, Net	5,793,927	2,236,130	-	8,030,057
TOTAL ASSETS	$ 13,283,870	$ 2,867,205	$ -	$ 16,151,075

LIABILITIES AND NET ASSETS

Current Liabilities:				
Accounts payable and accrued expenses	$ 174,455	$ -	$ -	$ 174,455
Accrued payroll and related expenses	947,248	-	-	947,248
Due to third party payers	73,250	-	-	73,250
Deferred revenue	3,125,597	-	-	3,125,597
Current maturities of long-term debt	50,176	32,594	-	82,770
Total Current Liabilities	4,370,726	32,594	-	4,403,320
Long-term Debt, Less Current Maturities	1,424,735	1,102,446	-	2,527,181
Total Liabilities	5,795,461	1,135,040	-	6,930,501
Net Assets:				
Unrestricted	7,099,125	1,720,008	-	8,819,133
Temporarily restricted	389,284	12,157	-	401,441
Total Net Assets	7,488,409	1,732,165	-	9,220,574
TOTAL LIABILITIES AND NET ASSETS	$ 13,283,870	$ 2,867,205	$ -	$ 16,151,075

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING BALANCE SHEET

SEPTEMBER 30, 2013

ASSETS

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Totals
Current Assets:				
Cash and cash equivalents	$ 1,580,568	$ 560,450	$ -	$ 2,141,018
Accounts receivable, net	697,315	-	-	697,315
Grants receivable	2,342,884	-	-	2,342,884
Other receivables	285,546	-	-	285,546
Other current assets	101,303	-	-	101,303
Total Current Assets	5,007,616	560,450	-	5,568,066
Assets Limited As To Use	1,864,232	119,294	-	1,983,526
Property And Equipment, Net	5,919,099	2,327,962	-	8,247,061
TOTAL ASSETS	$ 12,790,947	$ 3,007,706	$ -	$ 15,798,653

LIABILITIES AND NET ASSETS

Current Liabilities:				
Accounts payable and accrued expenses	$ 172,258	$ -	$ -	$ 172,258
Accrued payroll and related expenses	1,004,995	-	-	1,004,995
Due to third party payers	73,250	-	-	73,250
Deferred revenue	2,547,702	-	-	2,547,702
Current maturities of long-term debt	47,886	58,444	-	106,330
Total Current Liabilities	3,846,091	58,444	-	3,904,535
Long-term Debt, Less Current Maturities	1,472,529	1,265,606	-	2,738,135
Total Liabilities	5,318,620	1,324,050	-	6,642,670
Net Assets:				
Unrestricted	7,069,710	1,663,353	-	8,733,063
Temporarily restricted	402,617	20,303	-	422,920
Total Net Assets	7,472,327	1,683,656	-	9,155,983
TOTAL LIABILITIES AND NET ASSETS	$ 12,790,947	$ 3,007,706	$ -	$ 15,798,653

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Totals
Operating Revenue:				
Patient service revenue	$ 7,328,236	$ -	$ -	7,328,236
Provision for bad debts	(495,147)	-	-	(495,147)
Net patient service revenue	6,833,089	-	-	6,833,089
Rental income	-	227,916	(227,916)	-
Grants, contracts, and contributions, net	4,102,931	-	-	4,102,931
Other operating revenue	1,193,248	-	-	1,193,248
Net assets released from restriction for operations	-	8,146	-	8,146
Interest income	650	71	-	721
Total Operating Revenue	12,129,918	236,133	(227,916)	12,138,135
Operating Expenses:				
Payroll and related expenses	9,259,609	-	-	9,259,609
Other operating expenses	2,500,565	23,982	(227,916)	2,296,631
Depreciation	281,910	96,076	-	377,986
Interest expense	68,911	59,420	-	128,331
Total Operating Expenses	12,110,995	179,478	(227,916)	12,062,557
OPERATING INCOME AND EXCESS OF REVENUE OVER EXPENSES	$ 18,923	$ 56,655	$ -	$ 75,578

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING STATEMENT OF OPERATIONS

FOR THE YEAR ENDED SEPTEMBER 30, 2013

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Totals
Operating Revenue:				
Patient service revenue	$ 6,801,083	$ -	$ -	$ 6,801,083
Provision for bad debts	(401,602)	-	-	(401,602)
Net patient service revenue	6,399,481	-	-	6,399,481
Rental income	-	227,916	(227,916)	-
Grants, contracts, and contributions, net	3,933,920	-	-	3,933,920
Other operating revenue	2,470,950	-	-	2,470,950
Interest income	1,746	133	-	1,879
Total Operating Revenue	12,806,097	228,049	(227,916)	12,806,230
Operating Expenses :				
Payroll and related expenses	9,366,421	-	-	9,366,421
Other operating expenses	2,705,458	17,519	(227,916)	2,495,061
Depreciation	283,720	96,076	-	379,796
Interest expense	71,218	63,158	-	134,376
Total Operating Expenses	12,426,817	176,753	(227,916)	12,375,654
OPERATING INCOME AND EXCESS OF REVENUE OVER EXPENSES	$ 379,280	$ 51,296	$ -	$ 430,576

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Consolidated Totals
Unrestricted Net Assets:				
Excess of revenue over expenses	$ 18,923	$ 56,655	$ -	$ 75,578
Change in fair value of financial instrument	(2,841)	-	-	(2,841)
Net assets released from restrictions for capital acquisitions	13,333	-	-	13,333
Increase in Unrestricted Net Assets	29,415	56,655	-	86,070
Temporarily Restricted Net Assets:				
Net assets released from restrictions for operations	-	(8,146)	-	(8,146)
Net assets released from restrictions for capital acquisitions	(13,333)	-	-	(13,333)
Decrease in Temporarily Restricted Net Assets	(13,333)	(8,146)	-	(21,479)
Change in Net Assets	16,082	48,509	-	64,591
Net Assets, Beginning of Year	7,472,327	1,683,656	-	9,155,983
NET ASSETS, END OF YEAR	$ 7,488,409	$ 1,732,165	$ -	$ 9,220,574

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

CONSOLIDATING STATEMENT OF CHANGES IN NET ASSETS

FOR THE YEAR ENDED SEPTEMBER 30, 2013

	Lamprey Health Care, Inc.	Friends of Lamprey Health Care, Inc.	Eliminations	Consolidated Totals
Unrestricted Net Assets:				
Excess of revenue over expenses	$ 379,280	$ 51,296	$ -	$ 430,576
Change in fair value of financial instrument	56,115	-	-	56,115
Net assets released from restrictions for capital acquisitions	161,465	-	-	161,465
Increase in Unrestricted Net Assets	596,860	51,296	-	648,156
Temporarily Restricted Net Assets:				
Contributions, net	68,981	-	-	68,981
Net assets released from restrictions for capital acquisitions	(161,465)	-	-	(161,465)
Decrease in Temporarily Restricted Net Assets	(92,484)	-	-	(92,484)
Change in Net Assets	504,376	51,296	-	555,672
Net Assets, Beginning of Year	6,967,951	1,632,360	-	8,600,311
NET ASSETS, END OF YEAR	$ 7,472,327	$ 1,683,656	$ -	$ 9,155,983

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

Federal Grantor Pass-through Grantor Program Title	Federal CFDA Number	Pass-Through Entity Identifying Number	Federal Expenditures
U.S. Department of Health and Human Services			
Direct Programs			
Health Center Cluster	93.224		$ 2,417,609
Pass-through programs from:			
State of New Hampshire Department of Health and Human Services			
Family Planning	93.217	102-500734/90080203	100,853
Breast and Cervical Cancer Program	93.283	102-500731/90080081	57,750
Temporary Assistance for Needy Families	93.558	502-500891/45130203	29,719
Oral Health	93.991	102-500731/90072003	9,525
Primary Care	93.994	102-500731/90080000	40,151
The Homemakers Health Services			
Bureau of Elderly and Adult Services Grant	93.044	540-800382/14AANHT355	37,001
Dartmouth College			
Model State-Supported Area Health Education Centers	93.107	1382	76,500
Public Health Training Center	93.249	1383	22,500
Total U.S. Department of Health and Human Services			2,791,608
U.S. Department of Transportation			
Pass-through programs from:			
Cooperative Alliance for Seacoast Transportation			
Federal Transit Formula Grant	20.507	NH-90-X176	12,169
Total U.S. Department of Transportation			12,169
Total Expenditures of Federal Awards			$ 2,803,777

The accompanying notes are an integral part of this schedule.

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

NOTES TO THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

NOTE 1 BASIS OF PRESENTATION

The accompanying schedule of expenditures of federal awards, "the Schedule", includes the federal grant activity of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc., "the Organization", under programs of the federal government for the year ended September 30, 2014. The information in this schedule is presented in accordance with the requirements of the Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.* Because the schedule presents only a selected portion of the operations of the Organization, it is not intended to and does not present the financial position, changes in net assets, or cash flows of the Organization.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING PRINCIPLES

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in OMB Circular A-122, *Cost Principles for Non-Profit Organizations*, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Negative amounts shown on the Schedule, if any, represent adjustments or credits made in the normal course of business to amounts reported as expenditures in prior years. Pass-through entity identifying numbers are presented where available.

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Independent Auditors' Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Lamprey Health Care, Inc. and
Friends of Lamprey Health Care, Inc.
Newmarket, New Hampshire

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc., which comprise the balance sheet as of September 30, 2014, and the related statements of operations, changes in net assets, and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated December 23, 2014.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Organization's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

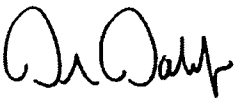
Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Organization's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.



Concord, New Hampshire
December 23, 2014

BRAD BORBIDGE, P.A.
CERTIFIED PUBLIC ACCOUNTANTS
197 LOUDON ROAD, SUITE 350
CONCORD, NEW HAMPSHIRE 03301

TELEPHONE 603/224-0849
FAX 603/224-2397

Independent Auditors' Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance

Board of Directors
Lamprey Health Care, Inc. and
Friends of Lamprey Health Care, Inc.
Newmarket, New Hampshire

Report on Compliance for Each Major Federal Program

We have audited Lamprey Health Care, Inc. and Friends of Lamprey Health Care, Inc.'s compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of the Organization's major federal programs for the year ended September 30, 2014. The Organization's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the Organization's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.* Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred.

An audit includes examining, on a test basis, evidence about the Organization's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the Organization's compliance.

Opinion on Each Major Federal Program

In our opinion, the Organization complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2014.

Report on Internal Control Over Compliance

Management is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Organization's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Purpose of this Report

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

Concord, New Hampshire
December 23, 2014

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

FOR THE YEAR ENDED SEPTEMBER 30, 2014

Section I - Summary of Auditors' Results

A. Financial Statements

1. Type of auditors' report issued	Unmodified
2. Internal control over financial reporting:	
• Material weakness(es) identified?	No
• Significant deficiencies identified?	None Reported
3. Noncompliance material to financial statements noted?	No

B. Federal Awards

1. Internal control over major programs:	
• Material weakness(es) identified?	No
• Significant deficiencies identified?	None Reported
2. Type of auditors' report issued on compliance for major programs	Unmodified
3. Any audit findings disclosed that are required to be reported in accordance with Section 510(a) of OMB Circular A-133?	No

C. Major Programs

Health Center Cluster	93.224

D. Dollar threshold used to distinguish between Type A and Type B programs $300,000

E. Auditee qualified as low-risk auditee? Yes

LAMPREY HEALTH CARE, INC.
AND FRIENDS OF LAMPREY HEALTH CARE, INC.

SCHEDULE OF FINDINGS AND QUESTIONED COSTS (CONTINUED)

FOR THE YEAR ENDED SEPTEMBER 30, 2014

Section II - Findings and Questioned Costs

A. Financial Statements

There were no financial statement findings for the year ended September 30, 2014.

B. Federal Awards

There were no federal awards findings for the year ended September 30, 2014.

Section III - Prior Findings and Questioned Costs

There were no prior financial statement or federal award audit findings for the year ended September 30, 2013.

LAMPREY HEALTH CARE

Board of Directors
2014 - 2015

Audrey Ashton-Savage (President)

George D. Donovan, Jr. (Vice President)

Carol LaCross (Treasurer)

Janis Reams (Secretary)

Elizabeth Crepeau
Immediate Past President

Thomas "Chris" Drew

Raymond Goodman, III

Frank Goodspeed

Mark E. Howard, Esq.

Amanda Pears Kelly

Michael Merenda

May 1, 2015

Gregory A. White, CPA

[redacted]

Summary

Senior Level Executive with extensive hands-on experience in management, business leadership, and working with boards, banks and other external stake holders. A CPA with an established record of success in Community Health Center management. Strong in budgets, cash forecasts, grants, and team leadership.

Professional Experience

Lamprey Health Care – Newmarket, NH **2013 to present**

Chief Executive Officer

- Responsible for the leadership, operation and overall strategic direction of New Hampshire's largest Federally Qualified Health Center.
- Ensuring continuity and high quality primary medical care in three sites, both urban rural, serving over 16,000 patients in 40 communities.
- Leading a high performing senior management team in the direction of over 150 staff and providers.
- Engaging with leaders and stakeholders at the local, state and national levels to ensure that Lamprey is at the forefront of innovative, high quality health care delivery.

Lowell Community Health Center – Lowell, MA **2009 to 2013**

Chief Financial Officer

- Responsible for the integrity of financial information and systems for this Federally Qualified Health Center, employing 315 staff and providing over 120,000 visits annually. Upgraded financial and administrative infrastructure to meet requirements during a time of rapid expansion.
- Lead the financing and budget development for a $42 million capital facility project to include: traditional debt, multiple tax credit sources, federal grants, loan guarantees, and private funds.
- Directed key projects for: 340(b) pharmacy implementation; 403(b) tax deferred savings plan; multiple federal stimulus grants; and revised operating budget development.
- Representative to the Lowell General PHO for managed care contract negotiation
- Recruited and managed a team of five directors to oversee and manage four support and one programmatic department

Manchester Community Health Center – Manchester, NH **1999 to 2009**

Chief Financial Officer

- Recruited by the CEO to bring structure and process to the functional areas of the Center's financial operations. Provided direction and oversight to key business areas; General Administration, Patient Registration, Human Resources, FTCA/Legal and Medical Records.

Gregory A. White, CPA

[redacted]

- Responsible for the development of key programs, Corporate Compliance, HIPAA, selection of a new practice management system. Supported Joint Commission accreditation and the implementation of an electronic medical record system.
- Led the development of financing for the Center's new facility.

Greater Lawrence Family Health Center – Lawrence, MA **1993 to 1998**

Controller **1997 to 1998**

Accounting Manager **1995 to 1997**

Senior Accountant/Analyst **1993 to 1995**

- Progressively responsible for all day to day financial operations of a Federally Qualified Health Center, including: Accounts Payable, Payroll, General Ledger, Cash Management, Cost Reporting, Patient Accounts, and Financial Reporting. Presented budgets, analysis, projections and periodic reporting to the Board of Directors.
- Key leader for projects involving: selection of new financial accounting software; selection of new practice management system; provider productivity measurement and analysis and group purchasing. Oversaw budget of $5 million construction project.
- Developed reimbursement model for an innovative Family Practice Residency program.

Alexander, Aronson, Finning & Co., CPA's – Westborough, MA **1990 to 1993**

Staff Accountant/Auditor

Education & Professional Affiliations

Babson College, Wellesley, MA

BS, Accounting - 1990

Commonwealth of Massachusetts

Certified Public Accountant- 1996

Healthcare Financial Management Association

Certified Healthcare Financial Professional - 2008

National Association of CHC's

Excel Leadership Program - 2003

National Registry of Emergency Medical Technicians

EMT - N.H. license number 18991-I

Boards, Advisory & Volunteer Experience

Massachusetts League of Community Health Centers – Special Finance Committee

Gregory A. White, CPA

[redacted]

NH Health Access Network – Administrative & Training Committee

Community Health Access Network – Board of Directors, Finance Committee

Bi-State Primary Care Association – Capital Finance & Sustainability, Prospective Payment

The Way Home – Manchester, NH - Board of Trustees – Treasurer

Manchester Sustainable Access Project – Data Sub-group

Milford Ambulance Service – Volunteer EMT, Staff Officer, Treasurer, Building Advisory Committee

Milford Educational Foundation – 1999 to 2010 - Treasurer

Heritage United Way – Manchester – Community Investment Committee

Milford Community Athletic Association - Coach

Lasell College – Co-Resident Director

SANDRA KNORR PARDUS

[redacted]

EXPERIENCE

Chief Fiscal Officer/Chief Information Officer **April 1981 to Present**
Lamprey Health Care, Inc., Newmarket, NH

- Facilitated the operational planning and budgeting and implementation for $12+ million Federally Qualified Health Center (FQHC). Net income was within 1% of budget for all years.
- Negotiated financing for the construction of eight medical/administrative facilities.
- Raised funds and implemented Electronic Health Record for four medical sites.
- Implemented Health Information Exchange for network of 10 FQHC's
- Played key role in discussion with New Hampshire's Department of Health and Human Services (DHHS) to insure adequate APM reimbursement for FQHC's in State of NH including the development of an FQHC billing manual.
- Led Accounting and IT Departments in the screening and hiring of audit professionals for 403B, annual and Security audits.
- Negotiated with managed care companies on contracts for commercial and Medicaid managed care.
- Researched and implemented 403B vendors with focus on performance and compliance.
- Developed an analysis of needs and possible vendors for insurance services, moving business to an A+ broker with a cost savings of 10%.
- Centralized purchasing role for the agency, standardizing supplies ordered with savings of 15%.
-

Network Information Officer
Community Health Access Network **July 1996 to present**

- Instrumental in the formation of a Health Center Controlled Network (HCCN), Community Health Access Network (CHAN), to standardize clinical operations between 10 FQHC's.
- Led the implementation of EHR at 10 member sites.
- Played key role in a major security upgrade to the CHAN infrastructure.
- Assisted in the development of standards for HCCN's through a Health Resources and Services Administration (HRSA) funded program focused on the expansion of HCCN's.

PROFESSIONAL MEMBERSHIP

National Association of Community Health Centers
Health Information and Management Systems Society

COMMITTEES

Bi-State Primary Care Association Finance Committee
Health Information and Management Systems Society Davies Award Committee

TRAININGS AND EDUCATION

Boston University, Boston, MA
Master of Business Administration
Information Systems Concentration, June 1991

University of New Hampshire, Durham, NH
Bachelor of Science, 1981

Harvard School of Public Health
Leadership Strategies for Information Technologies in Health Care, 2011

National Association of Community Health Centers (NACHC)
NACHC Financial and Operations Training Level 1, 2 and 3

AWARDS

2008 **HIMMS Davies Award of Excellence** was awarded to CHAN and Lamprey Health Care for their excellence in the implementation and value of health information technology and electronic health records (EHR).

2006 **Jeffrey T. Latman Award for Leadership in Health Care Finance** to Sandra Pardus by National Association of Community Health Centers for her achievements as an outstanding fiscal officer.

Paula K. Smith

[redacted]

[redacted]

EDUCATION

Rivier University, Nashua NH, Doctoral Program in Education, Leadership and Learning
Expected date of graduation 2017

American Evaluation Association/Centers for Disease Control, Summer Institute, June 2012

The Dartmouth Institute of Health Policy and Clinical Practice, Coach the Coach: The Art of Coaching and Improving Quality, Microsystems Process Improvement Training, 2009

American Society of Training & Development, Professional Trainer Certificate Program, Concord, NH, 2002.

Cultural Competency; Training of Trainers Program, CCHCP Training Institute, Seattle, WA,2000

University of Massachusetts, Boston, Harbor Campus, Boston, MA 02125
Masters in Business Administration, 1991

Boston University School of Public Health, Boston, MA
Negotiation and Conflict Resolution for Health Care Management
(Training Program), 1991

University of New Hampshire, Durham, NH
Bachelor of Science, Health Administration and Planning, 1985

PROFESSIONAL EXPERIENCE

February 1998 Present — **Director, Southern New Hampshire Area Health Education Center (AHEC)**
Lamprey Health Care, Raymond, NH

- Coordinates, plans and supervises the establishment and operation of a new AHEC center and programs designed to increase access to quality health care in southern NH.
- Partners with community-based providers and academic institutions to improve the supply and distribution of primary health care professionals and facilitates student placements in the community with an emphasis on medically underserved areas.
- Provides training opportunities for residents, nurse practitioners, social worker, physician assistant, nursing and medical students, as well as practicing providers.
- Develops and coordinates health care awareness programs for high school students with a focus on minority and disadvantaged populations.
- Coaches health center microteams in quality improvement initiatives.
- Oversees implementation of "Better Choices, Better Health" Chronic Disease Self-Management Program, including marketing, reporting, recruitment and management of leaders, and coordination of NH CDSMP Network, a learning community of leaders.

October 1995 to February 1998 — **Regional Services Coordinator**
New England Community Health Center Association, Woburn, MA

- Provided technical assistance, policy analysis, and other membership services to state primary care associations in New England and the community health centers they serve;
- Coordinated educational sessions for primary care clinicians and administrators on a variety of health care topics; assisted in developing program for two community health conferences a year, as well as one-day programs;
- Acted as liaison for members of MIS/Fiscal Directors and other regional committees;
- Wrote grants, including concept development, implementation plans and budget, for government and foundation proposals;
- Designed survey instruments, analyzed data, and wrote reports for region-wide surveys of community health centers, including compensation survey, needs assessment for locum tenens, survey on management information systems, and survey on productivity and staffing ratios;
- Acted as Project Director of Phase III of the Mammography Access Project;
- Wrote and distributed quarterly newsletter to health centers and public health organizations throughout New England.

February 1992 to October 1995 — **Program Director**
Department of Medical Security, Boston, MA

- Managed the Labor Shortage Initiative, a $23 million state-wide program providing education and training opportunities in health care occupations; oversaw the allocation of funds to participating hospitals, colleges and universities, and community organizations; supervised the development of contracts; monitored program achievements.

- Developed, implemented, and managed the *Children's Medical Security Plan*, a health insurance program for uninsured children under the age of 13; negotiated and monitored contracts totaling nearly $12 million with participating insurers; coordinated public relations and outreach activities related to the program; acted as a liaison with various advocacy groups.
- Managed *CenterCare*, a $4 million managed care program providing services through contracts with 30 community health centers across the state; allocated resources to participating centers; developed and conducted training sessions on *CenterCare* program operations for health center staff; analyzed demographic and utilization date of participants.

May 1990 to **Contract Manager**
February 1992 **Department of Medical Security, Boston, MA**

- Coordinated the procurement process for both *CenterCare* and the Labor Shortage Initiative, which included writing Requests for Proposals (RFPs), reviewing and analyzing proposals, monitoring the contracting and administration of funded proposals, and acting as a liaison between interested parties;
- Monitored *CenterCare* by coordinating payments to contractors, conducting site visits at participating community health centers, and reporting on program status; managed administrative procedures and acted as a liaison between agencies for all contracts in accordance with regulations.

October 1988 to **Contract Specialist**
May 1990 **Office of the State Comptroller, Boston, MA**

- Assisted and instructed departments in the process of contract approval, as well as utilization of the state-wide automated accounting systems (MMARS);
- Developed policies in support of state regulations pertaining to contract approval.
- Supervised contract officers in the review and approval of statewide consultant contracts; created reports to monitor departmental activities; organized special projects.

January 1988 to **Contract Officer**
October 1988 **Office of the State Comptroller, Boston, MA**

- Reviewed and approved transactions on MMARS submitted by departments throughout the Commonwealth;
- Managed Tax Exempt Lease Purchase program of all departments in the Commonwealth;
- Utilized word processing and spreadsheet programs.

September 1985 to **Administrative Assistant**
January 1988 **Joseph M. Smith Community Health Center, Alston, MA**

- Provided assistance to the Executive Director in overall administration of health center,
- Assisted Finance Director in management of accounts, and prepared monthly invoices for all grant reimbursement, utilizing word processing and spreadsheet programs.
- Supervised the payroll system and managed personnel files for 60 employees;
- Acted as liaison between outside vendors and health center;
- Interviewed candidates for support staff positions.

AFFILIATIONS
Endowment for Health Board of Advisors, 2013
Recipient of 2007 NH Office of Minority Health Women's Health Recognition Award
Leadership Board: American Lung Association of New Hampshire
Recipient of 2006 National AHEC Center for Excellence Award in Community Programming
Leadership New Hampshire 2003 Associate
Advisory Board Member- New Hampshire Minority Health Coalition
Member of National AHEC Organization
Member of the American Society of Training and Development
Organizational Recipient of 2002 Champions in Diversity Award for Education

References Available Upon Request

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: LAMPREY HEALTH CARE

Name of Program: Regional Public Health Network Services

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Greg White	CEO	$0	0.00%	[redacted]
Sandy Pardus	CFO	$0	0.00%	[redacted]
Paula Smith	Director	$98,842	6.40%	[redacted]
		$0	0.00%	[redacted]
		$0	0.00%	[redacted]
		$0	0.00%	[redacted]
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Greg White	CEO	$0	0.00%	[redacted]
Sandy Pardus	CFO	$0	0.00%	[redacted]
Paula Smith	Director	$100,819	6.00%	[redacted]
		$0	0.00%	[redacted]
		$0	0.00%	[redacted]
		$0	0.00%	[redacted]
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				[redacted]