EXHIBIT B.2

Arkansas State Claims Commission
FEB 0 6 2017
RECEIVED

Please Read Instructions on Reverse Side of Yellow copy
Please print in ink or type

BEFORE THE STATE CLAIMS COMMISSION
Of the State of Arkansas

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss
Preferred Family Healthcare, Inc. (PFH) **Claimant**
Formerly Alternative Opportunities (AO)
vs.

State of Arkansas, Respondent
AR. Department of Human Service/ Behavioral Health Service

Do Not Write in These Spaces	
Claim No.	17-0517-CC
Date Filed (Month) (Day) (Year)	February 6, 2017
Amount of Claim $	54,631.00
Fund	DHS/BHS
	Unpaid Bill

COMPLAINT

PFH Formerly AO (Name), the above named Claimant, of 1111 S Glenstone Ste 3-100 (Street or R.F.D. & No.) Springfield (City)
Mo (State) 65801 (Zip Code) 417-869-8911 (Daytime Phone No.) County of Greene represented by ____ (Legal Counsel, if any, for Claim)

of ____ (Street and No.) ____ (City) ____ (State) ____ (Zip Code) ____ (Phone No.) ____ (Fax No.), says:

State agency involved: AR Dept of Human Services Amount sought: $54631.00

Month, day, year and place of incident or service: June 1, 2015 - June 30, 2015

Explanation: We submitted invoice BSPA12 & BSPA12NEW on 7/16/15 for payment on PO 4501560833. They have never been paid due to a mixup on payments. We are resubmitting corrected invoices for payment. We have been working with Cheyonne Banks

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? Yes (Yes or No); when? 07 (Month) 16 (Day) 2015 (Year); to whom? AR Dept of Human Services - Div of Behavioral Health (Department); and that the following action was taken thereon: None

and that $ 0 was paid thereon: (2) Has any third person or corporation an interest in this claim? ____; if so, state name and address
____ (Name) ____ (Street or R.F.D. & No.) ____ (City) ____ (State) ____ (Zip Code)
and that the nature thereof is as follows: ____ ; and was acquired on ____, in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

Marilyn Nolan
(Print Claimant/Representative Name)

[signature]
(Signature of Claimant/Representative)

SWORN TO and subscribed before me at Springfield (City) MO (State)

on this 31st (Date) day of January (Month) 2017 (Year)

(SEAL) MELISSA S. SWOPE
Notary Public - Notary Seal
State of Missouri
Commissioned for Greene County
My Commission Expires: February 25, 2018
Commission Number: 14940586

Melissa S Swope
(Notary Public)

My Commission Expires: February (Month) 25 (Day), 2018 (Year)

SF1- R7/99

Bill To: **Arkansas Department of Human Services/Division of Behavioral Health Services**
4800 West 7th Street
Little Rock, Arkansas 72205
Telephone: (501) 686-9164 FAX: (501) 686-9035

BASIC SERVICES PROGRAM PLAN-PART A
MONTHLY PAYMENT AUTHORIZATION

CENTER:	Current Date: 7/16/2015
Name: Alternative Opportunities Inc.	Invoice #: BSPA12
Health Resources of Arkansas	
Address: 1111 S. Glenstone Ste 3-100	For the Period of:
	6/1/2015
City: Springfield State: MO ZIP: 65801	Through:
P.O. #: 4501516833 Vendor #: 600004801	6/30/2015

Funding Information	Amounts
Total Annual Allocation	$638,459.00
Plus: Mid Year Allocation Increase	$0.00
Less: Mid Year Allocation Reduction	$0.00
Net Payable Allocation	$638,459.00
Amount Received Year to Date	$585,255.00
Monthly BSP Part B Allocation	$53,204.00
Current Month Basic Services Program - Plan Part B Request:	$53,204.00
DHS USE: Adjustment Description:	
Total Billed Net:	

CERTIFICATION AND SIGNATURE:
By signing this invoice, I certify that the above stated information is correct to the best of my knowledge.
I also certify that services have been performed in accordance with the contract and all it's attachments.

Executive Director or Designee Date

PROFESSIONAL SERVICES:

Amount:	Amount:
Internal Order:	Internal Order:
Cost Center:	Cost Center:
Material #:	Material #:
General Ledger:	General Ledger:
P.O. Line #:	P.O. Line #:
Document #:	Document #:

Approved for Payment: Date

Revised: July, 2010

Bill To: **Arkansas Department of Human Services/Division of Behavioral Health Services**
4800 West 7th Street
Little Rock, Arkansas 72205
Telephone: (501) 686-9164 FAX: (501) 686-9035

BASIC SERVICES PROGRAM PLAN-PART A
MONTHLY PAYMENT AUTHORIZATION

CENTER:	Current Date: 7/16/2015
Name: Alternative Opportunities Inc.	Invoice #: BSPA12NW
Health Resources of Arkansas	
Address: 1111 S. Glenstone Ste 3-100	For the Period of: 6/1/2015
City: Springfield State: MO ZIP: 65801	Through: 6/30/2015
P.O. #: 4501516833 Vendor #: 600004801	

Funding Information	Amounts
Total Annual Allocation	$259,513.00
Plus: Mid Year Allocation Increase	$0.00
Less: Mid Year Allocation Reduction	$0.00
Net Payable Allocation	$259,513.00
Amount Received Year to Date	$258,086.00
Monthly BSP Part B Allocation	$1,427.00
Current Month Basic Services Program - Plan Part B Request:	$1,427.00
DHS USE: Adjustment Description:	
Total Billed Net:	

CERTIFICATION AND SIGNATURE:
By signing this invoice, I certify that the above stated information is correct to the best of my knowledge.
I also certify that services have been performed in accordance with the contract and all it's attachments.

Executive Director or Designee Date

PROFESSIONAL SERVICES:

Amount:	Amount:
Internal Order:	Internal Order:
Cost Center:	Cost Center:
Material #:	Material #:
General Ledger:	General Ledger:
P.O. Line #:	P.O. Line #:
Document #:	Document #:

Approved for Payment: Date

Revised: July, 2010

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

ALTERNATIVE OPPORTUNITIES **CLAIMANT**

v. **CLAIM NO. 17-0517-CC**

STATE OF ARKANSAS
DHS/DBHS **RESPONDENT**

ANSWER

Comes now the Respondent, Arkansas Department of Human Services, Division of Behavioral Health Services, by its attorney, Nick Windle for its Answer states:

1. Respondent admits liability in the amount of $54,631.00. Payment should be made as follows:

Agency Number:	0710
Cost Center:	417906
Internal Order:	HZ1X00XX
Fund:	PWP3500
Fund Center:	896

WHEREFORE, Respondent prays this claim be paid, and for all other just and equitable relief to which it may be entitled.

Respectfully submitted,

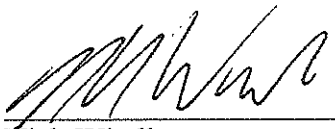
ARKANSAS DEPARTMENT
OF HUMAN SERVICES
OFFICE OF CHIEF COUNSEL

Nick R. Windle, No. 2010060
Attorney at Law
P.O. Box 1437 – Slot S260
Little Rock, Arkansas 72203-1437
Telephone: (501) 320-6351
Fax: (501) 682-1390
E-mail: Nicholas.Windle@DHS.Arkansas.Gov

CERTIFICATE OF SERVICE

I, undersigned, do hereby certify that on this 6th day of March, 2017, a true and correct copy of the foregoing pleading was sent to the following individual via U.S. mail.

Marilyn Nolan
Preferred Family Healthcare, Inc.
1111 S. Glenstone Avenue, Suite 3-100
Springfield, MO 65804



Nick Windle

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

ALTERNATIVE OPPORTUNITIES **CLAIMANT**

VS **CLAIM NO. 17-0517-CC**

ARAKNSAS DEPARTMENT OF HUMAN SERVICES-DIVISION OF BEHAVORIAL HEALTH SERVICES **RESPONDENT**

ORDER

This claim was filed by Alternative Opportunities against the Arkansas Department of Human Services–Division of Behavioral Health Sciences (the "Respondent") for an unpaid bill in the amount of $54,631.00.

The Respondent filed an Answer on March 6, 2017, admitting liability in the amount of $54,631.00.

The Claims Commission **hereby unanimously allows this claim in the amount of $54,631.00 and will include the claim in a claims bill to the 91st General Assembly, Arkansas State Legislature, for subsequent approval and payment.**

IT IS SO ORDERED.

Mica Strother

ARKANSAS STATE CLAIMS COMMISSION

Dexter Booth
Henry Kinslow, Co-Chair
Bill Lancaster
Sylvester Smith
Mica Strother, Co-Chair

DATE: April 13, 2017

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b)(3). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(b). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).