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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

Lori A. Shibinette
Commissioner

Patricia M. Tilley
Director

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

July 27, 2022

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

REQUESTED ACTION

Authorize the Department of Health and Human Services, Division of Public Health Services, to enter into a **Sole Source** contract with MaineHealth (VC# 177129), Portland, ME, in the amount of $60,000 to conduct tick surveillance, statewide, with the option to renew for up to two (2) additional years, effective upon Governor and Council approval through November 15, 2023. 100% Federal Funds.

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

05-95-90-903010-18350000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: PUBLIC HEALTH SERV DIV, BUREAU OF LABORATORY SERVICES, NH ELC

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2023	102-500731	Contracts for Program Services	90183509	$60,000
			Total	**$60,000**

EXPLANATION

This request is **Sole Source** because the vendor is uniquely qualified to provide essential services of tick collection and surveillance. The Department attempted to competitively bid the services defined in this contract. A Request for Proposals was posted in August 20, 2021 through September 23, 2021, with no response. The Department previously contracted with Maine Medical Center, and recognizes their distinctive qualifications to provide the services outlined in this contract. It is critical to know where ticks are active to properly assess the risk of tick-borne diseases in humans. Some illnesses, which include but is not limited to Lyme disease, anaplasmosis, babesiosis, and ehrlichiosis can be debilitating and potentially life threatening.

The purpose of this request is for the Contractor to complete tick-borne disease surveillance to monitor changes in the distribution and abundance of ticks and the presence and

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prevalence of tick-borne pathogens, statewide, in order to provide actionable, evidence-based information to clinicians, the public and public health policy makers.

The Contractor will establish baselines of presence or absence of ticks that include, Ixodes scapularis (Blacklegged tick), Amblyomma americanum (Lone Star tick), and Haemaphysalis longicornis (Asian Longhorned tick). The Contractor will identify ticks by stage and species to allow for appropriate pathogen testing, at each site, in accordance with Centers for Disease Control (CDC) guidance. The Contractor will provide the Department with all ticks collected, with details on each sample, by site, tick species, and collection date. The Department will coordinate the shipping of each sample to the CDC for testing.

The Department will monitor services by reviewing tick surveillance surveys completed at each site.

As referenced in Exhibit A of the attached agreement, the parties have the option to extend the agreement for up two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval.

Should the Governor and Council not authorize this request the Department will be unable to track and identify the prevalence of tick-borne pathogens, which could potentially lead to the spread of unknown tick related diseases.

Area served: Statewide

Source of Federal Funds: Assistance Listing Number #93.323, FAIN # NU50CK000522.

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

Respectfully submitted,

Ann W. Landry

FOR Lori A. Shibinette
Commissioner

Tick

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

Collection and Pathogen Testing for Tick-Borne Disease Surveillance (RFP-2022-DPHS-09-TICKS-01)

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name MaineHealth		1.4 Contractor Address 22 Bramhall Street Portland, ME 04102	
1.5 Contractor Phone Number (207) 662-0111	1.6 Account Number 05-95-90-903010-1835	1.7 Completion Date 11/15/2023	1.8 Price Limitation $60,000
1.9 Contracting Officer for State Agency Robert W. Moore, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature [signature] Date: 9/6/22		1.12 Name and Title of Contractor Signatory [handwritten name] CFO	
1.13 State Agency Signature DocuSigned by: Patricia M. Tilley Date: 9/8/2022		1.14 Name and Title of State Agency Signatory Patricia M. Tilley Director	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: DocuSigned by: Robyn Guarino On: 9/8/2022			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials [initials]
Date 9/6/22

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

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

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

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

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

Contractor Initials AGS
Date 2/6/22

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.
8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.
9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.
9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

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

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

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.
12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

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

Contractor Initials NCS
Date 9/1/22

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

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.
14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

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

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

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

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

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

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

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

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

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

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

Contractor Initials [illegible]
Date [illegible]

EXHIBIT A

Revisions to Standard Agreement Provisions

1. Revisions to Form P-37, General Provisions

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

3.3. The parties may extend the Agreement for up two (2) additional years from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and approval of the Governor and Executive Council.

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

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

1.3. Paragraph 13, Indemnification, is amended as follows:

13. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the Contractor, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

1.4. Paragraph 18, Choice of Law and Forum, is amended as follows:

18. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding

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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.

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EXHIBIT B

Scope of Services

1. Statement of Work

1.1. The Contractor shall conduct tick surveillance to monitor changes in the distribution and abundance of ticks and the presence and prevalence of tick-borne pathogens in order to provide actionable, evidence-based information to clinicians, the public, and public health policy makers.

1.2. The Contractor shall conduct tick surveillance at the following locations that include, but is not limited to:

County	Town	Site
Belknap	Alton	Merrymeeting Marsh WMA
Belknap	Tilton	Tilton Forest
Carroll	North Conway	Dahl Preserve
Carroll	Ossippee	Water District
Carroll	Ossippee	Pine River State Forest
Carroll	Freedom	Harmon Preserve -SPNHF
Coos	Colebrook	Beaver Brook Falls
Coos	Pittsburg	Lake Francis State Park
Grafton	Orange	Cardigan Mtn State Forest
Grafton	Hebron	Hebron Marsh WMA
Grafton	Groton	Cockermouth Forest
Grafton	Enfield	Enfield WMA
Sullivan	Springfield	Gile State Forest
Sullivan	Grantham	Grantham Town Forest
Strafford	Durham	Wagon Hill Farm
Merrimack	Concord	Karner Restoration
Merrimack	Northwood	Northwood Meadows State Park
Hillsborough	Manchester	Massabesic Watershed
Rockingham	Rye	Odiorne State Park

1.3. The Contractor shall establish baselines of presence or absence of ticks that include, but is not limited to:

1.3.1. Ixodes scapularis (Blacklegged tick).

1.3.2. Amblyomma americanum (Lone Star tick).

1.3.3. Haemaphysalis longicornis (Asian Longhorned tick).

1.4. The Contractor shall identify ticks by stage and species to allow for appropriate pathogen testing.

1.5. The Contractor shall coordinate with the Department's staff to review locations

in Section 1.2 in order to identify a minimum of 20 locations that will ensure statewide coverage for on-going active tick surveillance. The Contractor shall ensure:

1.5.1. Sites are chosen with the goal to produce regional estimates that are based on local factors that include, but are not limited to:

1.5.1.1. Relative incidence and location of reported human tick-borne disease cases;

1.5.1.2. Environmental conditions and habitats; and

1.5.1.3. Previous tick collecting efforts.

1.5.1.4. Sites include both well-established and emerging Ixodes scapularis habitats.

1.5.2. Sites and methods used are selected in accordance with Centers for Disease Control (CDC) guidance that include:

1.5.2.1. Surveillance for Ixodes scapularis and pathogens found in this tick species in the United States; and

1.5.2.2. Guide to the Surveillance of Metastriate Ticks (acari: Ixodidae) and their Pathogens in the United States.

1.6. The Contractor shall conduct active tick surveillance at designated locations at the following times:

1.6.1. A minimum of two (2) times per year in June 2023 or July 2023, targeting nymphal I. scapularis ticks; and

1.6.2. A minimum of two (2) times per year in October 2022, targeting adult Ixodes scapularis ticks.

1.7. The Contractor shall identify ticks collected by vegetation flagging and/or dragging surveys at each site, using flannel cloths measuring one (1) meter square dragged over vegetation, and in accordance with CDC guidance. The Contractor shall ensure:

1.7.1. Collection attempts last for a minimum of one (1) hour, which can be combined amongst the team, covering 1,000 linear meters, per site and ensure:

1.7.2. Collections at each site are broken into five (5) transects, each spanning two hundred (200) linear meters;

1.7.3. At each twenty (20) meter interval during collection that all flags are examined and ticks removed and placed in appropriate containers in accordance with guidance.

1.7.4. Collection attempts occur when environmental conditions are appropriate, which includes, but is in not limited to ensuring:

1.7.4.1. Collection occurs between 08:00 and 18:00.

1.7.4.2. Air temperature are between 10-35°C.

1.7.4.3. It is not raining.

1.7.4.4. There is low wind of less than 10 mph.

1.7.5. Information is collected during each collection attempt, which includes but is not limited to:

1.7.5.1. Location using global positioning system (GPS) coordinates.

1.7.5.2. Physical site description.

1.7.5.3. Number of person-hours spent on the collection attempt.

1.7.5.4. Distance covered to allow for tick density estimates.

1.7.5.5. Environmental parameters that include air temperature, relative humidity and weather conditions.

1.7.5.6. Ticks are placed in vials that minimize desiccation, which may include vials with moistened plaster-of-paris and/or refrigeration, as necessary, to ensure ticks remain alive prior to fixation.

1.7.5.7. Transportation of all collected ticks to a designated laboratory for identification, and subsequent reporting, of species and stage, which includes larvae, nymph, or adult.

1.7.6. All collected ticks are stored and shipped in 2.0 ml vials with 80% ethanol solution and stored at room temperature.

1.7.7. All ticks collected are shipped or hand-delivered to the DPHS Public Health Laboratories within two (2) weeks of collection.

1.7.8. Vials are appropriately labeled by species, site, date of collection and stage.

1.7.9. Paperwork accompanies samples indicating site location, collection date, number, and species of ticks submitted by stage.

1.7.10. Mail or email is sent to a designated Department staff member within one (1) month of tick collection information, which includes, but is not limited to:

1.7.10.1. GPS coordinates and physical description of collection site.

1.7.10.2. Number of person-hours spent for each collection attempt.

1.7.10.3. Distance covered during collection attempt.

1.7.10.4. Environmental parameters.

1.7.10.5. Tick abundance by species, stage and site.

1.8. Reporting

1.8.1. After each collection period as specified in Section 1.6, or as requested by Department, review active tick surveillance data to refine collection sites and strategies to meet the goals of this contract.

1.8.2. Prior to November 15, 2023, submit to the Department a final summary report including maps of tick abundance.

2. Exhibits Incorporated

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

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

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

3. Additional Terms

3.1. Impacts Resulting from Court Orders or Legislative Changes

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

3.2. Credits and Copyright Ownership

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

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

distribution or use.

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

3.2.3.1. Brochures.

3.2.3.2. Resource directories.

3.2.3.3. Protocols or guidelines.

3.2.3.4. Posters.

3.2.3.5. Reports.

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

4. Records

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

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

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

4.2. During the term of this Agreement and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Agreement for purposes of audit, examination, excerpts and transcripts. Upon the purchase by the Department of the maximum number of units provided for in the Agreement and upon payment of the price limitation hereunder, the Agreement and all the obligations of the parties hereunder (except such obligations as, by the terms of the Agreement are to be performed after the end of the term of this Agreement and/or survive the termination of the Agreement) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

EXHIBIT C

Payment Terms

1. This Agreement is funded with 100% Federal funds, Epidemiology and Laboratory Capacity for Infectious Diseases, as awarded on June 29, 2021, by the Centers for Disease Control and Prevention, CFDA 93.323, FAIN NU50CK000522.
2. For the purposes of this Agreement the Department has identified:
   2.1. The Contractor as a Contractor, in accordance with 2 CFR 200.331.
   2.2. The Agreement as NON-R&D, in accordance with 2 CFR §200.332.
3. Payment shall be for services provided in the fulfillment of this Agreement, as specified in Exhibit B Scope of Work, in the amount of $250 per hour.
4. The Contractor shall submit an invoice with supporting documentation to the Department no later than the fifteenth (15th) working day of the month following the month in which the services were provided. The Contractor shall ensure each invoice:
   4.1. Includes the Contractor's Vendor Number issued upon registering with New Hampshire Department of Administrative Services.
   4.2. Is submitted in a form that is provided by or otherwise acceptable to the Department.
   4.3. Identifies and requests payment for allowable costs incurred in the previous month.
   4.4. Includes supporting documentation of allowable costs with each invoice that may include, but are not limited to, time sheets, payroll records, receipts for purchases, and proof of expenditures, as applicable.
   4.5. Is completed, dated and returned to the Department with the supporting documentation for allowable expenses to initiate payment.
   4.6. Is assigned an electronic signature, includes supporting documentation, and is emailed to PHLAccountsPayable@dhhs.nh.gov or mailed to:

      Financial Manager
      Department of Health and Human Services
      129 Pleasant Street
      Concord, NH 03301
5. The Department shall make payments to the Contractor within thirty (30) days of receipt of each invoice and supporting documentation for authorized expenses, subsequent to approval of the submitted invoice.
6. The final invoice and supporting documentation for authorized expenses shall be due to the Department no later than forty (40) days after the contract

EXHIBIT C

completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

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

8. Audits

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

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

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

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

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

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

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

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

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

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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)

New Hampshire-Places vary according to tick surveillance activities outlined in scope of work.
Maine-MHIR 81 Research Drive, Scarborough, ME 04074

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

Contractor Name: MaineHealth

September 6, 2022
Date

Name: Albert G. Swallow III
Title: Chief Financial Officer

DocuSign Envelope ID: 33A3523C-9C02-4D34-8A4A-C628DAE9CF88

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Vendor Name: MaineHealth

September 6, 2022
Date

Name: Albert G. Swallow III
Title: Chief Financial Officer

DocuSign Envelope ID: 33A3523C-9C02-4D34-8A4A-C628DAE9CF88

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: MaineHealth

September 6, 2022
Date

Name: Albert G. Swallow III
Title: Chief Financial Officer

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

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

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

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

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

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

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

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

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

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

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

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

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

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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: MaineHealth

September 6, 2022
Date

Name: Albert G. Swallow III
Title: Chief Financial Officer

DocuSign Envelope ID: 33A3523C-9C02-4D34-8A4A-C628DAE9CF88

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: MaineHealth

Date 9/6/22

Name: Albert G. Swallow III
Title: Chief Financial Officer

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Business Associate Use and Disclosure of Protected Health Information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) **Obligations of Covered Entity**

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

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

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

(5) **Termination for Cause**

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

(6) **Miscellaneous**

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

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

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

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

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

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) l, 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.

	MaineHealth
The State	Name of the Contractor
Patricia M. Tilley	
Signature of Authorized Representative	Signature of Authorized Representative
Patricia M. Tilley	Albert G. Swallow III
Name of Authorized Representative	Name of Authorized Representative
Director	Chief Financial Officer
Title of Authorized Representative	Title of Authorized Representative
9/8/2022	September 6, 2022
Date	Date

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

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $30,000 and awarded on or after October 1, 2010, to report on data related to executive compensation and associated first-tier sub-grants of $30,000 or more. If the initial award is below $30,000 but subsequent grant modifications result in a total award equal to or over $30,000, the award is subject to the FFATA reporting requirements, as of the date of the award.
In accordance with 2 CFR Part 170 (Reporting Subaward and Executive Compensation Information), the Department of Health and Human Services (DHHS) must report the following information for any subaward or contract award subject to the FFATA reporting requirements:

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

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

Contractor Name: MaineHealth

September 6, 2022
Date

[signature]
Name: Albert G. Swallow III
Title: Chief Financial Officer

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FORM A

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

1. The UEI (SAM.gov) number for your organization is: MAYKB1LWD5U9

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

   __X__ NO _______ YES

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

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

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

   _______ NO _______ YES

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

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

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

   Name: ________________ Amount: __________

   Name: ________________ Amount: __________

   Name: ________________ Amount: __________

   Name: ________________ Amount: __________

   Name: ________________ Amount: __________

Contractor Initials [signature]

Date 9/6/22

New Hampshire Department of Health and Human Services

Exhibit K

DHHS Information Security Requirements

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

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

2. The Contractor must not disclose any Confidential Information in response to a

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

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

II. METHODS OF SECURE TRANSMISSION OF DATA

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

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

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

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

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

A. Retention

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

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

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

B. Disposition

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

2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.

3. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

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

1. The Contractor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services.

2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media used to store the data (i.e., tape, disk, paper, etc.).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16. The Contractor must ensure that all End Users:

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

    b. safeguard this information at all times.

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

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

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

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

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

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

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

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

V. LOSS REPORTING

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

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

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

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

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

VI. PERSONS TO CONTACT

A. DHHS Privacy Officer:

DHHSPrivacyOfficer@dhhs.nh.gov

B. DHHS Security Officer:

DHHSInformationSecurityOffice@dhhs.nh.gov

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State of New Hampshire
Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that MAINEHEALTH is a Maine Nonprofit Corporation registered to do business in New Hampshire as NORTHERN NEW ENGLAND POISON CENTER on February 21, 2008. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **591877**
Certificate Number: **0005789798**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 10th day of June A.D. 2022.

David M. Scanlan
Secretary of State

CERTIFICATE OF AUTHORITY

I, Beth Kelsch, being the duly elected Secretary of MaineHealth, a corporation organized and existing under and by virtue of the Laws of the State of Maine (hereinafter called this Corporation) do hereby certify as follows:

1. The Chief Executive Officer/President or the Treasurer has the authority to execute deeds, contracts and other documents on behalf of the Corporation pursuant to Section 11.1 of the Corporation's bylaws which remain in full force and effect on the date hereof as follows:

> Execution of Papers. All deeds, leases, transfers, contacts, bonds, notes, checks, drafts and other obligations made, accepted or endorsed by the Corporation shall be signed by the CEO/President or the Treasurer, or by persons designated in writing by the CEO/President or Treasurer, except that the Board of Trustees may by resolution restrict such power or authorize others to execute such documents.

2. Each of the following officer has been duly elected or appointed and is now legally holding the office opposite his or her name:

NAME	OFFICE
Dr. Andrew T. Mueller	Chief Executive Officer/President
Albert G. Swallow, III	Treasurer

3. This authority remains valid for thirty (30) days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on the certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to find the corporation in contacts with the State of New Hampshire, all such limitations are expressly stated herein.

DATED: September 6, 2022

Beth Kelsch, Secretary

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/09/2022

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

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

PRODUCER
Medical Mutual Insurance Company of Maine
One City Center PO Box 15275
Portland, ME 04112

CONTACT NAME:
PHONE (A/C, No, Ext): 2077752791 FAX (A/C, No): 2075238320
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Medical Mutual Ins Co of Maine	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
MaineHealth Services
110 Free Street
Portland ME 04101

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			ME CHL 004693	10/01/2021	10/01/2022	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 50,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 12,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 12,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

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

CERTIFICATE HOLDER

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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MAINE

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/13/2022

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

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

PRODUCER	CONTACT NAME: Mary Roy	
USI Insurance Services, LLC 75 John Roberts Road, Building C South Portland, ME 04106 855 874-0123	PHONE (A/C, No, Ext): 855 874-0123	FAX (A/C, No): 877-775-0110
	E-MAIL ADDRESS: Mary.Roy@usi.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Phoenix Insurance Company	25623
INSURED MaineHealth Services 22 Bramhall Street Portland, ME 04102-3175	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES — CERTIFICATE NUMBER: — REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE / OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY / PRO-JECT / LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		UB5K2905132243G	03/01/2022	03/01/2023	X PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$1,000,000
							E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000

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

This certificate is issued for insured operations usual to MaineHealth Services.

CERTIFICATE HOLDER	CANCELLATION
State of NH Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE [signature]

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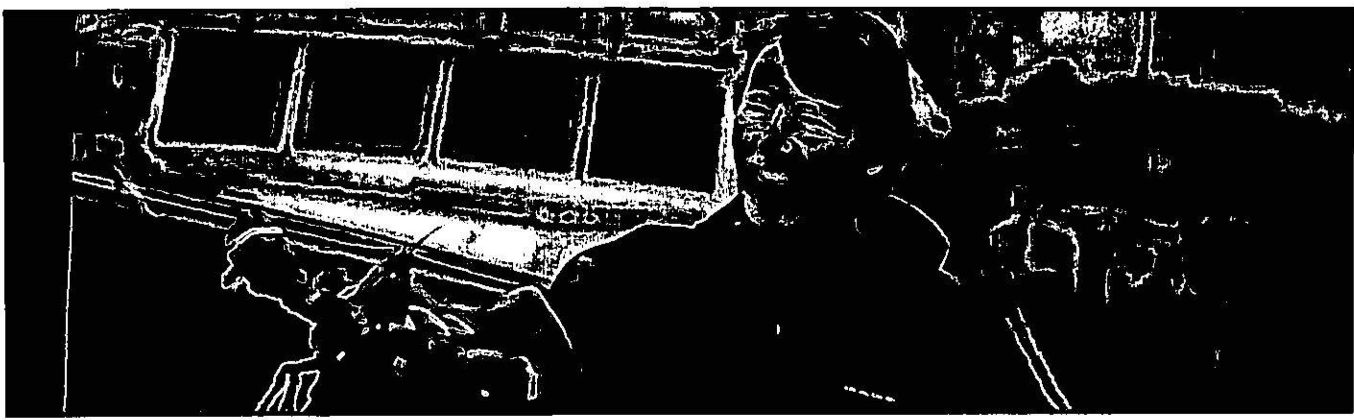
MaineHealth



Mission and Vision

Our Vision

Working together so our communities are the healthiest in America.

Our Mission

MaineHealth is a not-for-profit health system dedicated to improving the health of our patients and communities by providing high-quality affordable care, educating tomorrow's caregivers, and researching better ways to provide care.

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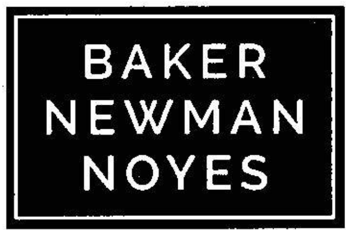

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

Consolidated Financial Statements and Supplementary
Information and Government Reports
in Accordance With Uniform Guidance

Years Ended September 30, 2021 and 2020
With Independent Auditors' Report

Baker Newman & Noyes LLC
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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

Consolidated Financial Statements and Supplementary Information and
Government Reports in Accordance With Uniform Guidance

Years Ended September 30, 2021 and 2020

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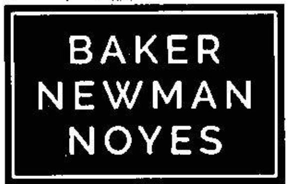

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INDEPENDENT AUDITORS' REPORT

Board of Directors
MaineHealth Services and Subsidiaries

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of MaineHealth Services and Subsidiaries, which comprise the balance sheets as of September 30, 2021 and 2020, the related consolidated statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

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

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

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

Board of Directors
MaineHealth Services and Subsidiaries

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of MaineHealth Services and Subsidiaries as of September 30, 2021 and 2020, and the results of their operations, changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards, as required by Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, is presented for purposes of additional analysis and is not a required part of the 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 information is fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated February 4, 2022 on our consideration of MaineHealth Services and Subsidiaries' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of MaineHealth Services and Subsidiaries' internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering MaineHealth Services and Subsidiaries' internal control over financial reporting and compliance.

Baker Newman + Noyes LLC

Portland, Maine
February 4, 2022, except as to the Supplementary
Schedule of Expenditures of Federal Awards and
Report on Compliance for each Major Federal Program
for which the date is June 6, 2022

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED BALANCE SHEETS

September 30, 2021 and 2020
(In thousands)

Assets	2021	2020
Current assets:		
Cash and cash equivalents	$ 435,441	$ 547,872
Investments	1,195,752	868,416
Accounts receivable	367,554	286,156
Current portion of investments whose use is limited	200,695	256,272
Inventories, prepaid expenses and other current assets	147,717	120,312
Total current assets	2,347,159	2,079,028
Investments whose use is limited by:		
Debt agreements	198,255	253,844
Board designation	155,405	139,138
Self-insurance trust agreements	47,006	49,904
Specially designated specific purpose funds	77,827	77,077
Plant replacement funds	1,648	961
Funds functioning as endowment funds	156,219	133,328
Pooled life income funds	2,546	2,417
Beneficial interest in perpetual and charitable remainder trusts	56,782	48,302
	695,688	704,971
Less current portion	(200,695)	(256,272)
	494,993	448,699
Property, plant and equipment - net	1,445,798	1,396,118
Right of use assets	160,178	176,780
Other assets	184,173	171,549
Total assets	$ 4,632,301	$ 4,272,174

Liabilities and Net Assets	2021	2020
Current liabilities:		
Current portion of long-term debt	$ 41,994	$ 42,842
Current portion of lease obligation	17,406	21,079
Accounts payable and other current liabilities	378,361	210,735
Accrued payroll, payroll taxes and amounts withheld	101,392	62,500
Accrued earned time	106,852	90,149
Accrued interest payable	6,374	5,737
Estimated amounts payable under reimbursement regulations	57,925	52,265
Self-insurance reserves	34,888	33,877
Deferred revenue	17,080	16,202
Total current liabilities	762,272	535,386
Accrued retirement benefits	296,716	411,113
Self-insurance reserves – less current portion	55,136	46,209
Estimated amounts payable under reimbursement regulations	-	4,984
Long-term debt, less current portion	755,585	797,595
Long-term lease obligation – less current portion	146,366	157,633
Other liabilities	74,847	270,629
Total liabilities	2,090,922	2,223,549
Net assets:		
Without donor restrictions	2,232,624	1,774,871
With donor restrictions	308,755	273,754
Total net assets	2,541,379	2,048,625
Total liabilities and net assets	$ 4,632,301	$ 4,272,174

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF OPERATIONS

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Revenue:		
Patient service revenue	$3,016,241	$2,474,304
Direct research revenue	16,914	17,832
Indirect research revenue	5,508	4,676
Other revenue	413,038	388,047
Total revenue and other support	3,451,701	2,884,859
Expenses:		
Salaries	1,603,003	1,469,471
Employee benefits	422,666	370,734
Supplies	564,232	462,461
Professional fees and purchased services	320,936	261,541
Facility and other costs	137,026	119,133
State taxes	51,381	50,431
Interest	18,654	17,720
Depreciation and amortization	161,645	153,600
Total expenses	3,279,543	2,905,091
Income (loss) from operations	172,158	(20,232)
Nonoperating gains (losses):		
Gifts and donations – net of related expenses	1,990	2,860
Interest and dividends	27,151	15,794
Recognized gain (loss) on cash flow hedge instruments	4,191	(2,499)
Nonservice periodic pension costs	(15,748)	(19,639)
Equity in earnings of joint ventures	7,293	6,983
Increase in fair value of investments	78,192	63,655
Contribution of net assets from acquired affiliates	-	157,646
Other	3,180	(728)
Total nonoperating gains - net	106,249	224,072
Excess of revenue and nonoperating gains – net over expenses	278,407	203,840
Net assets released from restrictions for property, plant and equipment	52,102	11,494
Retirement benefit plan adjustments	127,244	17,092
Increase in net assets without donor restriction	$ 457,753	$ 232,426

See accompanying notes to consolidated financial statements.

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CHANGES IN NET ASSETS
Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Net assets without donor restrictions:		
Excess of revenue and nonoperating gains – net over expenses	$ 278,407	$ 203,840
Net assets released from restrictions for property, plant and equipment	52,102	11,494
Retirement benefit plan adjustments	127,244	17,092
Increase in net assets without donor restriction	457,753	232,426
Net assets with donor restrictions:		
Gifts and donations	56,730	24,297
Interest and dividends	2,652	1,301
Change in value of perpetual and beneficial interest trusts	9,372	920
Realized and unrealized gains on investments	33,369	16,177
Net assets released for operations	(15,020)	(10,795)
Net assets released for property, plant and equipment	(52,102)	(11,494)
Contribution of net assets from acquired affiliates	–	30,290
Increase in net assets with donor restrictions	35,001	50,696
Increase in net assets	492,754	283,122
Net assets – beginning of year	2,048,625	1,765,503
Net assets – end of year	$2,541,379	$2,048,625

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Cash flows from operating activities:		
Increase in net assets	$ 492,754	$ 283,122
Adjustment to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	161,645	153,600
Accretion of bond issuance cost and premium, net	(3,267)	(1,590)
Equity in earnings of joint ventures	(7,293)	(6,983)
Net realized and change in unrealized gains on investments	(111,561)	(79,832)
Net (gain) loss on cash flow hedge instruments	(4,191)	2,499
Net gain on charitable remainder and perpetual trusts	(8,481)	(2,010)
(Gain) loss on disposal of fixed assets	(493)	94
Noncash lease expense	(20,252)	(24,795)
Restricted contributions and investments income	(59,382)	(25,657)
Retirement benefit plan adjustments	(127,244)	(17,092)
Increase in asset retirement obligations	(62)	–
Net assets of acquired affiliates	–	(187,936)
Increase (decrease) in cash resulting from a change in:		
Patient accounts receivable	(81,398)	16,905
Inventories, prepaid expenses and other current assets	(27,405)	(2,460)
Other assets	(12,475)	(18,942)
Accounts payable and other current liabilities	221,182	87,761
Operating lease liability	21,914	26,727
Amounts (receivable) payable under reimbursement regulations	676	(5,408)
Self-insurance reserves	9,938	8,401
Accrued retirement benefits	12,847	29,939
Other liabilities	(191,529)	203,141
Net cash provided by operating activities	265,923	439,484
Cash flows from investing activities:		
Purchase of investments	(1,290,407)	(1,049,527)
Proceeds from sale of investments	1,092,396	833,282
Increase in other assets	27	6,586
Distributions from joint ventures	7,430	5,736
Contributions to joint ventures	(4,082)	–
Purchases of property, plant and equipment	(209,468)	(226,195)
Proceeds from sale of fixed assets	2,137	531
Cash and cash equivalents of acquired affiliates	–	7,561
Net cash used by investing activities	(401,967)	(422,026)
Cash flows from financing activities:		
Payments of long-term debt	(59,104)	(33,008)
Payments of finance lease obligations	(2,406)	(2,637)
Proceeds from issuance of long-term debt	21,563	282,812
Amounts paid to refinance	–	(33,915)
Restricted contributions and investment income	63,560	24,544
Net cash provided by financing activities	23,613	237,796
Net (decrease) increase in cash and cash equivalents	(112,431)	255,254
Cash and cash equivalents – beginning of year	547,872	292,618
Cash and cash equivalents – end of year	$ 435,441	$ 547,872

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

CONSOLIDATED STATEMENTS OF CASH FLOWS (CONTINUED)

Years Ended September 30, 2021 and 2020
(In thousands)

	2021	2020
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 32,784	$ 23,188
Supplemental disclosure of noncash activities:		
Right of use assets obtained in exchange for lease obligations:		
Operating leases	$ –	$ 205,755
Financing leases	$ 895	$ 94
Purchases of property, plant and equipment in accounts payable and other current liabilities	$ 19,922	$ 16,368

See accompanying notes to consolidated financial statements.

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

September 30, 2021 and 2020

1. Reporting Entity

Organization

The MaineHealth System (the System) is comprised of MaineHealth Services, the parent organization, and its subsidiaries. The subsidiaries of MaineHealth Services include MaineHealth, NorDx, MaineHealth Care at Home, and The Memorial Hospital at North Conway, N.H. The subsidiary MaineHealth includes nine acute care hospitals that were formerly individual entities until the execution of a unification merger effective January 1, 2019 at which time eight of the nine hospitals merged. Mid Coast Hospital merged in a separate transaction on January 1, 2021. These hospitals are now local health systems within the subsidiary named MaineHealth utilizing d/b/a's of Maine Medical Center, Southern Maine Health Care, Mid Coast–Parkview Health (Mid Coast Hospital), LincolnHealth, Western Maine Healthcare (Stephens Memorial Hospital), Franklin Community Health Network (Franklin Memorial Hospital), Maine Behavioral Healthcare, and Coastal Healthcare Alliance (Waldo County General Hospital and Pen Bay Medical Center). The merger enables the combined resources of the merging entities to be allocated in a manner that is consistent with the System's vision of helping make the communities it serves the healthiest in America.

MaineHealth Services, together with its controlled subsidiaries, MaineHealth and The Memorial Hospital at North Conway, N.H., maintained a controlling interest in MaineHealth Accountable Care Organization, LLC (MaineHealth ACO), a value based contracting entity.

Since all the merged entities had been under the common control of the parent organization, formerly known as MaineHealth, and were already included in the System's consolidated financial statements,. there was no impact on the financial reporting resulting from unification.

The purpose of the System is to lead the development of a premier community care network that provides a broad range of integrated health care services for populations in Maine and northern New England. Through the System's member organizations, the network provides services along the full continuum of care as necessary to improve the health status of the populations it serves. As such, revenue includes those generated from direct patient care services, amounts earned from incentive and risk arrangements, the provision of medical education and training services, federal and state grants and contracts, sundry revenue generated from the operations of the subsidiaries, fund-raising conducted to support the activities of the System and its subsidiaries, and investment earnings.

Acquisitions

On March 1, 2020, MaineHealth Services became the sole corporate member of Mid Coast–Parkview Health (MCPH). Membership in the MaineHealth System will provide MCPH with opportunities to improve the health of the communities in the Mid Coast region and strengthen the ability to provide high quality, safe patient care to local communities, while striving to increase access to tertiary services and lowering health care costs. No consideration was transferred in connection with the MCPH acquisition. A second transaction occurred on January 1, 2021, in which Mid Coast Hospital merged into MaineHealth. The remaining MCPH subsidiaries, Community Health and Nursing Services (CHANS), Mid Coast Geriatric Services Corporation (MCGSC), Mid Coast Medical Group, Thornton Oaks Development Corp. and Mid Coast Health Management Corporation became subsidiaries of MaineHealth.

1. Reporting Entity (Continued)

The consolidated statement of operations for 2020 includes seven months of operations of MCPH. In 2020, the consolidated statement of operations includes unrestricted revenue and other support of $117,725,000, and a deficit of revenues over expense of $9,427,000.

The amounts assigned to major assets and liabilities at the acquisition date were as follows (in thousands):

Current assets	$ 61,745
Property and equipment	72,728
Other noncurrent assets	86,178
Current liabilities	(35,784)
Long-term liabilities	(27,221)
Contribution of net assets from acquired affiliates	$157,646

As a result of the acquisition, the System's net assets without donor restrictions were increased by $157,646,000 as a contribution of net assets from acquired affiliates and net assets with donor restrictions were increased by $30,290,000.

The MCPH transaction was accounted for as an acquisition in accordance with Financial Accounting Standards Board Accounting Standards Codification (ASC) 958-805, *Not-for-profit Mergers and Acquisitions*, which required the assets and liabilities to be accounted for at fair value, as of the date of the acquisition. The fair value of the net assets at the date of the acquisition was recognized as a contribution of net assets from acquired affiliates as part of nonoperating gains, and net assets with donor restrictions.

COVID-19 Pandemic and CARES Act and Other Relief Funding

In February 2020, the Center for Disease Control (CDC) confirmed the spread of the COVID-19 disease to the United States. On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic. The State of Maine confirmed its first case on March 12, 2020. In an effort to slow the spread of the disease, the Governor of the State of Maine declared a state of emergency on March 15, 2020, followed by orders requiring schools and nonessential businesses to close, limiting gatherings, and ordering people to stay at home. On March 18, 2020, the Centers for Medicare and Medicaid Services (CMS) issued guidance that all elective surgeries and procedures, including medical and dental, should be postponed nationwide to mitigate the burden on health systems of increasing COVID-19 incidence and to make necessary facilities, equipment, supplies (including personal protective equipment, or "PPE") and personnel available to treat patients presenting COVID-19 symptoms. In response to the pandemic, MaineHealth began delaying or cancelling all nonemergent or elective procedures on March 16, 2020 and followed subsequent guidance issued by CMS. No such state or federal requirements were placed on MaineHealth in the fiscal year ended September 30, 2021. However, throughout the year, on an as needed basis, MaineHealth deferred nonurgent activity in order to maintain sufficient available beds for the most emergent admissions.

1. Reporting Entity (Continued)

During the year ended September 30, 2020, the System received $243,707,000 of accelerated Medicare payments. Payments under the Medicare Accelerated and Advanced Payment program are advances that must be repaid. At September 30, 2021, $50,554,000 had been repaid. The balance of the funds remaining of $193,153,000 was recorded as a short-term liability at September 30, 2021. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) also authorized the deferral of employment tax payment. At September 30, 2021, $27,169,000 in deferred payroll taxes was recorded as a short term liability and $27,169,000 was recorded as a long-term liability. At September 30, 2020, $36,553,000 in deferred payroll taxes was recorded as a long-term liability.

In addition, during the years ended September 30, 2021 and 2020, the System received $84,897,000 and $138,117,000, respectively, in relief funds and grants from federal and state sources that is not required to be repaid, subject to use towards eligible expenses and lost revenues incurred as a result of the COVID-19 pandemic. During the year ended September 30, 2021, the System has recognized $85,128,000 in relief funding as revenue. During the year ended September 30, 2020, the System recognized $134,906,000 in relief funding as revenue. MaineHealth's assessment of meeting the terms and conditions of each grant was based on incurrence of eligible uses under the terms and conditions of each grant. MaineHealth's assessment of whether the terms and conditions have been met for amounts received in CARES Act PRF payments were based on the Post-Payment Notice of Reporting Requirements issued by Health and Human Services (HHS) on January 15, 2021. Additionally, MaineHealth has completed the required reporting for Reporting Period 1, for all payments received through June 30, 2020. Subsequent Reporting Periods are planned to be opened by Health Resources and Services Administration (HRSA) in January 2022. Under such guidance, and in the HRSA reporting portal for Reporting Period 1, PRF payments were applied first to healthcare related expenses attributable to the coronavirus that another source has not reimbursed and is not obligated to reimburse. PRF payment amounts not fully expended on healthcare related expenses attributable to the coronavirus were then applied to lost revenues, calculated on a quarterly basis for each reporting tax identification number (TIN). HRSA allows for such lost revenue calculations to be performed as the difference between actual 2019 and actual current year quarterly revenues, the difference between 2020 budget and actual current year quarterly revenues, or by any alternate reasonable method of estimating lost revenues. Each MaineHealth reporting TIN has calculated lost revenues using one of these three methodologies. As of September 30, 2021, MaineHealth recognized all CARES Act PRF payments that were required to be used by September 30, 2021 and MaineHealth does not anticipate repaying PRF payments received through September 30, 2021. As of September 30, 2021, MaineHealth recorded $2,980,000 in relief funds as deferred revenue. The majority of the relief funds, $2,593,000, were state funds received near the end of the fiscal year 2021 for which MaineHealth has not yet identified eligible expenditures.

2. Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of the System. The consolidated financial statements have been presented in conformity with accounting principles generally accepted in the United States of America (GAAP) consistent with the FASB ASC Topic 954, *Health Care Entities*, and other pronouncements applicable to health care organizations. The assets of any member of the consolidated group may not be available to meet the obligations of other members in the group, except as disclosed in Note 10. Upon consolidation, intercompany transactions and balances have been eliminated.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. Significant estimates are made in the areas of patient accounts receivable, the fair value of financial instruments, amounts receivable and payable under reimbursement regulations, asset retirement obligations (AROs), retirement benefits and self-insurance reserves.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt securities purchased with a maturity at the date of purchase of three months or less, excluding amounts classified as investments whose use is limited.

Investments

Investments are stated at fair value. The recorded value of investments in hedge funds and limited partnerships is based on fair value as estimated by management using information provided by external investment managers. The System has applied the provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities that Calculate Net Asset Value (NAV) per Share (or its Equivalent)*. This standard allows for the estimation of the fair value of investments in investment companies for which the investment does not have a readily determinable fair value using NAV per share or its equivalent as a practical expedient. The System has utilized the NAV reported by each of the underlying funds as a practical expedient to estimate the value of the investment for each of these funds. The System believes that these valuations are a reasonable estimate of fair value as of September 30, 2021 and 2020, but are subject to uncertainty and, therefore, may differ from the value that would have been used had a market for the investments existed. Such differences could be material. Certain of the hedge fund and limited partnership investments have restrictions on the withdrawal of the funds (see Note 8). Investments are classified as current assets based on the availability of funds for current operations. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in the excess of revenues and nonoperating gains – net over expenses, unless the income or loss is restricted by donor or law. The accounting for the pension plan assets is disclosed in Note 8.

2. Significant Accounting Policies (Continued)

As provided for under ASC Topic 825, *Financial Instruments*, the System made the irrevocable election to report investments and investments whose use is limited at fair value with changes in value reported in the excess of revenues and nonoperating gains – net over expenses. As a result of this election, the System reflects changes in the fair value, including both increases and decreases in value whether realized or unrealized, in its excess of revenues and nonoperating gains – net over expenses.

Investments, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility. As such, it is reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the consolidated financial statements.

Investments Whose Use is Limited

Investments whose use is limited primarily include investments held by trustees under debt agreements, self-insurance trust agreements, and designated investments set aside by the Board of Trustees (of member Boards) for purposes over which those Boards retain control and may at their discretion subsequently use for other purposes. In addition, investments whose use is limited include investments restricted by donors for specific purposes or periods, as well as investments restricted by donors to be held in perpetuity by the System, and the related appreciation on those investments. Amounts required to meet current liabilities of the System have been classified as current assets.

Property, Plant and Equipment

Property, plant, and equipment are recorded at cost, or at fair value at the date of acquisition, if acquired in a business combination accounted for using the acquisition method of accounting. Depreciation is provided over the estimated useful life of each class of depreciable assets and is computed using the straight-line method. Interest costs incurred on borrowed funds during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets. MaineHealth recorded capitalized interest of $11,500,000 and $3,610,000 for the years ended September 30, 2021 and 2020, respectively.

Gifts of long-lived assets, such as land, building, or equipment, are reported as increases in net assets without restrictions and are excluded from the excess of revenues and nonoperating gains – net over expenses. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Impairment of Long-Lived Assets

Long-lived assets to be held and used are reviewed for impairment whenever circumstances indicate that the carrying amount of an asset may not be recoverable. Long-lived assets to be disposed of are reported at the lower of carrying amount or fair value, less cost to sell.

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2. Significant Accounting Policies (Continued)

Asset Retirement Obligations

AROs, which are included in other liabilities in the accompanying consolidated balance sheets, are legal obligations associated with the retirement of long-lived assets. These liabilities are initially recorded at fair value and the related asset retirement costs are capitalized by increasing the carrying amount of the related assets by the same amount as the liability. Asset retirement costs are subsequently depreciated over the useful lives of the related assets. Subsequent to initial recognition, the System records period-to-period changes in the ARO liability resulting from the passage of time, increases or decreases in interest expense, and revisions to either the timing or the amount of the original expected cash flows to the related assets.

Accounting for Defined Benefit Pension and Other Postretirement Plans

The System recognizes the overfunded or underfunded status of its defined benefit and postretirement plans as an asset or liability in its consolidated balance sheets. Changes in the funded status of the plans are reported as a change in net assets without restrictions presented below the excess of revenues and nonoperating gains – net over expenses in its consolidated statements of operations and changes in net assets in the year in which the changes occur.

The measurement of benefit obligations and net periodic benefit cost is provided by third-party actuaries based on estimates and assumptions approved by the System's management. These valuations reflect the terms of the plans and use participant-specific information, such as compensation, age, and years of service, as well as certain assumptions, including estimates of discount rates, expected long-term rate of return on plan assets, rate of compensation increases, interest-crediting rates, and mortality rates.

Assets Limited or Restricted as to Use

Assets limited or restricted as to use include assets held by trustees under bond indenture agreements, assets restricted for self-insurance, assets held for supplemental retirement benefits, and assets restricted by donors for specific purposes or endowment. Amounts required to meet current liabilities of the System are classified as current assets.

Beneficial Interests in Perpetual Trusts

Beneficial interests in perpetual trusts consist of the System's proportionate share of the fair value of assets held by trustees in trust for the benefit of the System in perpetuity, the income from which is available for distribution to the System periodically. The assets held in trust consist primarily of cash equivalents and marketable securities. The fair values of perpetual trusts are measured using the net asset value as a practical expedient. Such amounts are included in assets whose use is limited in the accompanying consolidated balance sheets. Distribution from beneficial interests in perpetual trusts is included in nonoperating gains, unless restricted by donors.

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2. Significant Accounting Policies (Continued)

Excess of Revenues and Nonoperating Gains – Net Over Expenses

The consolidated statements of operations include excess of revenues and nonoperating gains – net over expenses as the performance indicator. Changes in net assets without donor restrictions, which are excluded from excess of revenues and nonoperating gains – net over expenses, consistent with industry practice, include retirement benefit plan adjustments, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and capital grants.

Consolidated Statements of Operations

For purpose of display, transactions deemed by management to be ongoing, major, or central to the provision of health care and related services are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating gains and losses.

Patient Service Revenue

Revenues generally relate to contracts with patients in which the System's performance obligations are to provide health care services to patients. Revenues are recorded during the period obligations to provide health care services are satisfied. Performance obligations for inpatient services are generally satisfied over a period of days. Performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payor (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by Medicare and Medicaid or negotiated with managed care health plans and commercial insurance companies, the third-party payors. The payment arrangements with third-party payors for the services provided to related patients typically specify payments at amounts less than standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the revenue recognition process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

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2. Significant Accounting Policies (Continued)

The collection of outstanding receivables for Medicare, Medicaid, managed care payers, other third-party payors and patients is the System's primary source of cash and is critical to its operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the aging of those accounts. Accounts are written off when all reasonable internal and external collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical write-offs and collections at facilities that represent a majority of hospital revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. Management performs the hindsight analysis for contractual reserves every six months and a twenty-four month hindsight analysis for accounts receivable collection and write-off data. Management believes its regular updates to the estimated implicit price concession amounts provide reasonable estimates of revenues and valuations of accounts receivable. These routine, regular changes in estimates have not resulted in material adjustments to the valuations of accounts receivable or period-to-period comparisons of operations. At September 30, 2021 and 2020, estimated implicit price concessions of $156,766,000 and $122,514,000, respectively, had been recorded as reductions to patient service revenue to enable the System to record revenues and accounts receivable at the estimated amounts expected to be collected.

Free Care

The System provides care without charge to patients who meet certain criteria under its Board-established free care policies. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue.

Direct and Indirect Research Revenue and Related Expenses

Revenue related to research grants and contracts is recognized as the related costs are incurred. Indirect costs relating to certain government grants and contracts are reimbursed at fixed rates negotiated with the government agencies. Research grants and contracts are accounted for as exchange transactions or contributions. Amounts received in advance of incurring the related expenditures are recorded as unexpended research grants and are included in deferred revenue.

Other Revenue

Revenue which is not related to patient medical care but is central to the day-to-day operations of the System is included in other revenue. This revenue includes pharmacy sales, cafeteria sales, medical school revenue, grant revenue, rental revenue, net assets released from restrictions for operations, COVID-19 relief revenue and other support services revenue.

2. Significant Accounting Policies (Continued)

Gifts and Donations

Unconditional promises to give cash and other assets to the System are reported at fair value at the date the promise is received. Unconditional promises to give that are expected to be collected in future years are recorded at the present value of estimated future cash flows. The discounts on those amounts are computed using a risk-free rate applicable to the year in which the promise is received. Amortization of the discount is included in contribution revenue. Conditional promises to give are recognized when the conditions are substantially met. The gifts are reported as net assets with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations as net assets released from donor restrictions, which is included in other revenue. Donor-restricted contributions whose restrictions are met within the same year received are reported as unrestricted contributions in the accompanying consolidated financial statements.

Self-Insurance Reserves

The liabilities for outstanding losses and loss-related expenses and the related provision for losses and loss-related expenses include estimates for losses incurred but not reported as well as losses pending settlement. Such liabilities are based on estimates and, while management believes the amounts provided are adequate, the ultimate liability may be greater than or less than the amounts provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The methods for making the workers compensation and malpractice estimates and the resulting liability are actuarially reviewed on an annual basis, and any necessary adjustments are reflected in current operations.

Income Tax Status

The Internal Revenue Service has previously determined that the System and its subsidiaries (except Maine Medical Partners (MMP) (a subsidiary of MaineHealth) are organizations as described in Section 501(c)(3) of the Internal Revenue Code (IRC) and are exempt from federal income taxes on related income pursuant to Section 501(a) of the IRC. MMP had significant net operating loss carryovers as of September 30, 2021 and 2020. A valuation allowance has been provided for the entire deferred tax benefit for the net operating losses, due to uncertainty of realization. MMP did not have material taxable income in 2021 and 2020. Accordingly, a provision for income taxes has not been made in the accompanying consolidated financial statements.

The System recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount of benefit that is greater than fifty percent likely to be realized upon settlement. Changes in measurement are reflected in the period in which the change in judgment occurs. The System did not recognize the effect of any income tax positions in either 2021 or 2020.

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2. Significant Accounting Policies (Continued)

Subsequent Events

Events occurring after the consolidated balance sheet date are evaluated by management to determine whether such events should be recognized or disclosed in the consolidated financial statements. Management has evaluated subsequent events through February 4, 2022, which is the date the consolidated financial statements were available to be issued.

3. Liquidity and Availability of Financial Assets

The System's working capital and cash flows are subject to variability during the year attributable to changes in volume and cash receipts. The System maintains investments portfolios without donor restrictions to manage fluctuations in cash flow.

The following table (in thousands) reflects the System's financial assets for the period ending September 30, 2021, reduced by amounts not available for general use within one year because of contractual or donor-imposed restrictions or internal designations. Investment amounts would be available, subject to liquidity of the underlying investments.

Cash and cash equivalents	$ 435,441
Investments	1,195,752
Accounts receivable	367,554
Financial assets available to meet cash needs for general expenditures within one year	$1,998,747

Cash and cash equivalents includes $193,153,000 of accelerated Medicare payments received under the Medicare Accelerated and Advanced Payment program. A liability of $193,153,000 has been recorded in accounts payable and other current liabilities.

In addition to the amounts listed above, the System has available to it lines of credit in the amount of $100,000,000 which it could draw upon to meet the current needs of the System.

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4. Community Benefit Programs

As a nonprofit organization dedicated to community health improvement, the System provides many services for the community in addition to its range of health care services and programs. The System supports improvement in community health by implementing best practice interventions ranging from prevention and wellness to disease management. These services include evidence-based programs to improve care and outcomes for people suffering from chronic diseases such as diabetes, asthma, chronic obstructive pulmonary disease and behavioral health issues. The System also provides training and education opportunities for physicians and other providers that focus on achieving patient-centered healthcare. In addition, the System works to ensure patients receive excellent coordination of care through transitions of care programs. The System also offers, through its Access to Care program, donated healthcare services and free or low-cost medications to low-income and uninsured patients.

A wide range of community health improvement and prevention programs support the efforts to promote healthy lifestyles. The System's healthy lifestyle programs include initiatives that target both children and adults. Engaging community health professionals and provider organizations, community partners, family members and local and state government is a key component to the successful implementation and continued effectiveness of these programs. The System's tobacco cessation program, through highly trained Tobacco Treatment Educators, provides ongoing support to the community healthcare providers with the goal of reducing tobacco use. This program also offers a free confidential coaching service in support of Maine residents who seek to quit the use of tobacco. Over the past four years, the System has also invested significant resources in implementing a multi-faceted approach to addressing the opioid crises experienced by Maine and New Hampshire. Other community health improvement programs include healthy lifestyle, oral health, healthy weight, and childhood immunization initiatives.

5. Patient Service Revenue

The System records patient service revenue at the amount that reflects the consideration to which the System expects to be entitled to in exchange for providing patient care. Patient service revenue consists of amounts charged for services rendered less estimated discounts for contractual and other allowances for patients covered under Medicare, Medicaid and other health plans and discounts offered to patients under the System's uninsured discount program.

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

5. Patient Service Revenue (Continued)

Medicare and State Medicaid Programs

Maine Medical Center, Southern Maine Health Care, Pen Bay Medical Center, Mid Coast—Parkview Health and Franklin Memorial Hospital are paid at prospectively determined rates for inpatient and outpatient services rendered to Medicare and Medicaid beneficiaries. Inpatient rates vary according to a patient classification system that is based on clinical diagnosis and other factors. Outpatient services are paid based on a prospective rate per ambulatory visit or procedure. LincolnHealth, Waldo County General Hospital, Stephens Memorial Hospital and The Memorial Hospital are Critical Access Hospitals reimbursed at cost for services provided to Medicare and Medicaid beneficiaries for certain services. Cost reimbursable services are paid at an interim rate with final settlement determined after submission, review and audit of annual cost reports by the System and audit thereof by the Medicare administrative contractor, the State of Maine and the State of New Hampshire.

Several System hospitals receive Disproportionate Share Hospital (DSH) payments. These payments are made to qualifying hospitals to cover the costs of providing care to low income patients. These payments are subject to audit by CMS and are, therefore, subject to change. These amounts are recorded as patient service revenue.

In 2004, the State of Maine established several health care provider taxes (State taxes). The enactment of the State taxes allowed the State of Maine to add revenues to the State of Maine General Fund while minimizing the potential of lost federal matching funds in the MaineCare program. The hospital-specific portion of the State taxes on Maine hospitals is based on a percentage of patient service revenue. Taxes on nursing homes are based on 6.0% of patient service revenue.

The State of New Hampshire established a Medicaid Enhancement Tax program in 1991. This program taxes hospital services at approximately 2.3% of patient service revenue. The State of New Hampshire also levies a tax on intermediate care facilities at approximately 5.5%.

For the years ended September 30, 2021 and 2020, the System recorded State taxes of $51,381,000 and $50,431,000, respectively.

Nongovernmental Payors

The System also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the System under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

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5. Patient Service Revenue (Continued)

Uninsured Patients

For uninsured patients who do not qualify for free care, the System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). Based on historical experience, a significant portion of uninsured patients will be unable or unwilling to pay for the services provided.

Consistent with the System's mission, care is provided to patients regardless of their ability to pay. The System has determined it has provided self-pay allowances to uninsured patients and patients with other uninsured balances (e.g. copays and deductibles). The self-pay allowances included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the System expects to collect based on its collection history with those patients.

The System provides care without charge to patients who meet certain criteria under its Board-established free care policy. Because the System does not pursue collection of amounts determined to qualify as free care, they are not reported as patient service revenue. The System estimates the costs associated with providing charity care by calculating a ratio of total cost to total gross charges, and then multiplying that ratio by the gross charges associated with providing care to patients eligible for free care. The estimated cost of caring for free care patients for the years ended September 30, 2021 and 2020, was $28,533,000 and $43,757,000, respectively. Funds received from gifts and grants to subsidize charity services provided for the years ended September 30, 2021 and 2020, were $250,000 and $434,000, respectively.

Patient service revenue from these major payor sources recognized during the years ended September 30, 2021 and 2020 was as follows (in thousands):

	2021	2020
Medicare	$1,064,004	$ 860,547
State Medicaid Programs	412,067	340,418
Anthem Blue Cross and Blue Shield	634,447	545,416
Other third-party payors	827,131	684,372
Patients	78,592	43,551
Total patient service revenue	$3,016,241	$2,474,304

Patient service revenue in 2021 and 2020 included $5,783,000 and $493,000, respectively, of favorable settlements with third-party payors regarding prior year activities.

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6. Concentration of Credit Risk

Receivables

Financial instruments, which potentially subject the System to concentration of credit risk, consist of patient accounts receivable, estimated amounts receivable under reimbursement regulations, and certain investments. Investments, which include government and agency securities, stocks, and corporate bonds, are not concentrated in any corporation or industry. The System grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at September 30, 2021 and 2020, was as follows:

	2021	2020
Medicare	35%	34%
State Medicaid Programs	13	15
Anthem Blue Cross and Blue Shield	12	12
Other third-party payors	23	24
Patients	17	15
Total patient receivables	100%	100%

Cash

The System maintains its cash accounts at various financial institutions. As of September 30, 2021 and 2020, the System had cash balances of $171,112,000 and $37,512,000, respectively, in uninsured accounts. The System has not experienced any losses in such accounts and evaluates the credit worthiness of the financial institutions with which it conducts business. Management believes the System is not exposed to any significant credit risk with respect to its cash balances.

Labor Force

The System's unionized labor workforce are members of the Maine State Nurses Association/National Nurses Organizing Committee and National Nurses United. It is approximately 9.1% of the System's work force. The union is currently without a contract and is actively in contract negotiations.

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7. Investments and Investments Whose Use is Limited

The composition of investments and investments whose use is limited at September 30, 2021 and 2020, is set forth as follows (in thousands):

	2021	2020
Investments (current assets)	$1,195,752	$ 868,416
Investments whose use is limited	695,688	704,971
	$1,891,440	$1,573,387
Cash equivalents	$ 261,471	$ 312,366
Fixed income securities – bonds	702,146	511,013
Equity investments – stocks	582,469	485,034
Investment in real property	1,874	2,125
Limited partnerships	128,758	91,856
Hedge funds	157,940	122,691
Beneficial interest in perpetual and charitable remainder trusts	56,782	48,302
	$1,891,440	$1,573,387

Investments whose use is limited include amounts required by debt agreements, amounts restricted by donors, assets designated by the Board for future capital improvements, assets to fund self-insured professional and general liability and workers' compensation risks, and to provide for other specific purposes.

Investments whose use is limited by debt agreements include debt service funds, which are composed of semiannual deposits to fund principal and interest payments, and construction funds. These investments are held pursuant to the requirements of the outstanding Revenue Bonds and Revenue Refunding Bonds.

The amounts reported as trusteed under debt agreements consisted of construction funds from the 2020 and 2018A Series bond issues, capitalized interest funds that will be used to pay future payments on the 2018A and 2018B Series bond issues, and funds accumulated for future principal and interest payments on the 2014A, 2018A and 2018B, and the 2020 Series bond issues.

8. Fair Value of Financial Instruments

Fair Value Measurements

The System classifies its investments into Level 1, which refers to securities valued using quoted prices from active markets for identical assets, Level 2, which refers to securities not traded on an active market, but for which observable market inputs are readily available, and Level 3, which refers to securities with unobservable inputs that are used when little or no market data is available. Assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement.

Asset Valuation Techniques

Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs. The following is a description of the valuation methodologies used for assets measured at fair value:

Cash equivalents – The investments strategy for these are low-risk, low-return, highly liquid investments, typically with a maturity of three months or less, including U.S. Government, T-bills, bank certificates, corporate commercial paper or other money market instruments that are based on quoted prices and are actively traded.

Fixed income securities-bonds – These securities are investments in corporate or sovereign bonds and notes, certificates of deposit, or other loans providing a periodic payment and eventual return of principal at maturity. Certain corporate bonds and notes are valued at the closing price reported in the active market in which the bond is traded. Other corporate bonds and notes are valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flow approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks.

Equity investments-stocks – These investments include marketable equity securities, mutual funds, exchange traded, and closed-end funds. The fair value of marketable equity securities are principally based on quoted market prices. Exchange-traded funds and closed-end funds are valued at the last sale price or official closing price on the exchange or system on which they are principally traded. Investments in mutual funds are valued at their NAV at year end. These funds are required to publish their daily NAV and to transact at that price. The mutual funds held are deemed to be actively traded.

Investment in real property – Investments in real property are valued yearly at fair value, using the market approach, as determined by comparable sales data beginning on the date of acquisition.

Common/collective trusts – These include diverse investments in securities issued by the U.S. Treasury and global bond funds using the Common Collective Trust vehicle to obtain lower expense ratios. These investments are designed to generate attractive risk-adjusted returns. The fair value of common collective trusts are based on the NAV of the fund, representing the fair value of the underlying investments, which are generally securities traded on an active market. The NAV as provided by the trustee, is used as a practical expedient to estimate fair value.

8. Fair Value of Financial Instruments (Continued)

Limited partnerships – These include investments in offshore and private equity funds. They have objectives of capital appreciation with absolute returns over the medium and long term. These investments are designed to generate attractive risk-adjusted returns. The estimated fair values of limited partnerships for which quoted market prices are not readily available, are determined based upon information provided by the fund managers. Such information is generally based on NAV of the fund, which is used as a practical expedient to estimate fair values. The limited partnerships invest primarily in readily available marketable equity securities. The limited partnerships allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective partnership agreements.

Hedge funds – The investments are inclusive of a variety of types of equity, debt, and derivative investments, designed to mitigate volatility while generating equity like returns. The estimated fair values of limited partnerships and hedge funds, for which quoted market prices are not readily available, are determined based upon information provided by the fund managers. Such information is generally based on NAV of the fund, which is used as a practical expedient to estimate fair value. The hedge funds invest primarily in readily marketable equity securities. The hedge funds allocate gains, losses, and expenses to the partners based on ownership percentage as described in the respective hedge fund agreements.

The following methods and assumptions were used by the System in estimating the fair value of the System's financial instruments that are not measured at fair value on a recurring basis for disclosures in the consolidated financial statements:

Interest rate swaps – The System uses inputs other than quoted prices that are observable to value the interest rate swaps. The System considers these inputs to be Level 2 inputs in the context of the fair value hierarchy. The fair value of the net interest rate swap liabilities was $11,151,000 and $15,342,000 at September 30, 2021 and 2020, respectively. These values represent the estimated amounts the System would receive or pay to terminate agreements, taking into consideration current interest rates and the current creditworthiness of the counterparty. The fair value of the interest rate swap agreements are reported in other long-term liabilities.

Pledges receivable – The current yields for 1 to 10-year U.S. Treasury notes are used to discount pledges receivable. The System considers these yields to be a Level 2 input in the context of the fair value hierarchy. Pledges received were discounted at rates ranging from 0.90% to 2.08% in fiscal year 2021 and from 0.12% to 3.50% in fiscal year 2020. Outstanding pledges receivable in 2021 and 2020, which have been recorded within other long-term assets at fair value, totaled $26,904,000 and $25,830,000, respectively.

Receivables and payables – The carrying value of the System's receivables and payables approximate fair value, as maturities are very short term.

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8. Fair Value of Financial Instruments (Continued)

The System's investments at fair value set forth by level within the fair value hierarchy as of September 30, 2021 and 2020 are as follows (in thousands):

	Investments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total
September 30, 2021					
Cash equivalents	$ –	$ 261,471	$ –	$ –	$ 261,471
Investments:					
Fixed income securities – bonds	116	261,875	440,155	–	702,146
Equity investments – stocks	–	528,501	53,968	–	582,469
Investment in real property	1,874	–	–	–	1,874
Limited partnerships	128,758	–	–	–	128,758
Hedge funds	157,940	–	–	–	157,940
Beneficial and charitable remainder trusts	–	–	–	56,782	56,782
Total investments	288,688	790,376	494,123	56,782	1,629,969
Total cash equivalents and investments	$288,688	$1,051,847	$494,123	$56,782	$1,891,440
September 30, 2020					
Cash equivalents	$ –	$ 312,366	$ –	$ –	$ 312,366
Investments:					
Fixed income securities – bonds	315	158,921	351,777	–	511,013
Equity investments – stocks	–	437,464	47,570	–	485,034
Investment in real property	2,125	–	–	–	2,125
Limited partnerships	91,856	–	–	–	91,856
Hedge funds	122,691	–	–	–	122,691
Beneficial and charitable remainder trusts	–	–	–	48,302	48,302
Total investments	216,987	596,385	399,347	48,302	1,261,021
Total cash equivalents and investments	$216,987	$ 908,751	$399,347	$48,302	$1,573,387

The net change in the beneficial interest in perpetual and charitable remainder trusts of $8,480,000 and $1,730,000, in 2021 and 2020 respectively, represents the change in the fair value of the trusts, net of distributions.

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8. Fair Value of Financial Instruments (Continued)

The information regarding the fair value measurements of the assets held by the System's defined benefit pension plan (see Note 13) at September 30, 2021 and 2020, is as follows (in thousands):

	Investments Measured at NAV	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Total
September 30, 2021					
Cash equivalents	$ –	$ 11,608	$ –	$ –	$ 11,608
Investments:					
Fixed income securities – bonds	–	34,770	43,575	–	78,345
Equity investments – stocks	–	334,206	42,294	–	376,500
Common/collective trusts	26,634	–	–	–	26,634
Limited partnerships	109,683	–	–	–	109,683
Hedge funds	256,736	–	–	–	256,736
Total investments	393,053	368,976	85,869	–	847,898
Total cash equivalents and investments	$393,053	$380,584	$85,869	$ –	$ 859,506
September 30, 2020					
Cash equivalents	$ –	$ 23,384	$ –	$ –	$ 23,384
Investments:					
Fixed income securities – bonds	–	27,445	40,762	–	68,207
Equity investments – stocks	–	293,555	38,534	–	332,089
Common/collective trusts	29,206	–	–	–	29,206
Limited partnerships	87,358	–	–	–	87,358
Hedge funds	205,971	–	–	–	205,971
Total investments	322,535	321,000	79,296	–	722,831
Total cash equivalents and investments	$322,535	$344,384	$79,296	$ –	$ 746,215

Liquidity

Equity investments, fixed income investments, investments in real property, common collective trusts, limited partnerships and hedge funds are redeemable at NAV under the terms of the subscription and/or partnership agreements. Investments, including short-term investments, with daily liquidity generally do not require any notice prior to withdrawal. Investments with monthly, quarterly or annual redemption frequency typically require notice periods ranging from 30 to 180 days. The long term investments fair value are broken out below by their redemption frequency as of September 30, 2021 and 2020 for both the investments and the System's defined benefit pension plan (in thousands):

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8. Fair Value of Financial Instruments (Continued)

Investments Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2021							
Fixed income securities – bonds	$ –	$ –	$ –	$ –	$ 116	$ –	$ 116
Investment in real property	–	–	–	–	1,874	–	1,874
Limited partnerships	–	64,272	11,906	37,927	14,653	–	128,758
Hedge funds	2,131	–	42,400	106,973	6,436	–	157,940
	$ 2,131	$ 64,272	$ 54,306	$144,900	$ 23,079	$ –	$288,688
September 30, 2020							
Fixed income securities – bonds	$ –	$ –	$ –	$ –	$ 315	$ –	$ 315
Investment in real property	–	–	–	–	2,125	–	2,125
Limited partnerships	–	46,985	9,756	24,420	10,695	–	91,856
Hedge funds	2,259	–	29,902	89,170	1,360	–	122,691
	$ 2,259	$ 46,985	$ 39,658	$113,590	$ 14,495	$ –	$216,987

Defined Benefit Pension Investments Liquidity – NAV Measured Investments	Daily	Bi-Monthly	Monthly	Quarterly	Illiquid	Annually	Total
September 30, 2021							
Common/collective trusts	$ –	$ –	$ 26,634	$ –	$ –	$ –	$ 26,634
Limited partnerships	–	59,543	–	49,757	–	383	109,683
Hedge funds	54,983	–	38,875	146,542	16,336	–	256,736
	$ 54,983	$ 59,543	$ 65,509	$196,299	$ 16,336	$ 383	$393,053
September 30, 2020							
Common/collective trusts	$ –	$ –	$ 29,206	$ –	$ –	$ –	$ 29,206
Limited partnerships	–	52,577	–	33,907	–	874	87,358
Hedge funds	48,057	–	40,701	117,213	–	–	205,971
	$ 48,057	$ 52,577	$ 69,907	$151,120	$ –	$ 874	$322,535

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8. Fair Value of Financial Instruments (Continued)

Investments with a redemption frequency of illiquid may include lock-ups with definite expiration dates, restricted shares and side pockets, as well as private equity and real assets funds where the System has no liquidity terms until the investments are sold by the fund manager. The System has total capital commitments for alternative investments outstanding of $8,804,000 and $6,491,000 as of September 30, 2021 and 2020 respectively. Specific short-term investments within the System's portfolio will be used to fund this commitment. Investments associated with beneficial interests in perpetual trust agreements have been categorized as illiquid because they are not available to support operations.

Transfers Between Levels

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period. There were no transfers between Level 1 and Level 2 for the years ended September 30, 2021 and 2020.

The valuation methods as described above may produce a fair value calculation that may not be indicative of what the management would realize upon disposition or reflective of future fair values. Furthermore, although management believes its valuation methods are appropriate and consistent with methods employed by other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

9. Property, Plant and Equipment

Property, plant, and equipment at September 30, 2021 and 2020, consist of the following (in thousands):

	2021	2020
Land and land improvements	$ 118,451	$ 116,781
Buildings	1,760,081	1,646,066
Equipment	1,391,986	1,339,290
Construction in progress	160,921	134,478
	3,431,439	3,236,615
Less accumulated depreciation and amortization	(1,985,641)	(1,840,497)
Total property, plant and equipment, net	$ 1,445,798	$ 1,396,118

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9. Property, Plant and Equipment (Continued)

As of September 30, 2021 and 2020, the remaining commitment on construction contracts was approximately $185,273,000 and $242,191,000, respectively. The value of property, plant, and equipment acquisitions in accounts payable at September 30, 2021 and 2020, was $19,922,000 and $16,368,000, respectively.

Information Technology Investment

The System has nearly completed a significant investment in its information technology systems. A significant project to acquire and implement an ambulatory electronic health record began in 2007, was expanded in 2010 to include the inpatient electronic health record system and other financial systems and then was expanded again in 2016 to include Maine Behavioral Healthcare and System members who joined the System since 2010. As of September 30, 2021, $334,000,000 had been expended. The expected remaining amount to complete the project is $9,500,000.

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10. Long-Term Debt and Revolving Lines of Credit

Long-term debt at September 30, 2021 and 2020 consists of the following (in thousands):

Name of Issue	Interest Rate	Type of Rate	Final Maturity	2021	2020
Revenue bonds:					
Maine Health and Higher Educational Facilities Authority (MHHEFA):					
Franklin Memorial Hospital – Series 2016A	3.0%-5.0%	Fixed	2034	$ 7,789	$ 8,274
Maine Medical Center – MaineHealth – Series 2020	4.0%-5.0%	Fixed	2050	205,214	205,213
Maine Medical Center – Series 2018A	5.0%	Fixed	2048	164,330	164,330
Maine Medical Center – Series 2018B	3.84%-3.94%	Fixed	2028	10,930	10,930
Maine Medical Center – Series 2018C	(81.5%* 1 Month Libor)+0.652%	Variable	2036	36,735	36,735
Maine Medical Center – Series 2014	3.0%-5.0%	Fixed	2044	79,675	79,675
Quarry Hill – Series 2017A	4.0%-5.0%	Fixed	2030	5,959	6,589
Pen Bay Medical Center – Series 2017B	3.0%-5.0%	Fixed	2038	5,653	6,113
Waldo County General Hospital – Series 2014A	3.0%-5.0%	Fixed	2028	2,982	3,412
Southern Maine Health Care – Maine Health – Series 2020	4.0%-5.0%	Fixed	2050	7,487	7,487
Southern Maine Health Care – Series 2016A	4.0%-5.0%	Fixed	2026	3,925	5,665
Stephens Memorial Hospital – Series 2014	2.0%-5.0%	Fixed	2039	3,385	3,735
Finance Authority of Maine:					
MaineHealth – Series 2017	2.11%	Fixed	2027	38,586	45,252
MaineHealth – Series 2014	2.36%	Fixed	2025	48,793	60,045
Southern Maine Health Care – Series 2013	2.91%	Fixed	2033	11,028	11,796
New Hampshire Health and Education Facilities Authority:					
The Memorial Hospital at North Conway (sub. of TMH) – Series 2016	4.0%-5.5%	Fixed	2036	12,455	12,990
Note payable:					
MaineHealth – Series 2020A	1.5%	Fixed	2030	–	21,115
MaineHealth – Series 2020B	1.7%	Fixed	2031	13,875	15,260
MaineHealth – Series 2021A	1.47%	Fixed	2030	18,830	–
MaineHealth	3.0%	Fixed	2025	3,464	4,258
MaineHealth	Adj Libor + 95 basis pts	Variable	2031	8,251	8,962
MaineHealth	Adj Libor + 95 basis pts	Variable	2031	7,928	8,612
Mid Coast-Parkview Health	3.2%	Fixed	2027	19,750	23,042
Other, including finance leases				24,191	31,316
Total bonds, loans, notes payable and finance leases before bond issuance costs and premiums				741,215	780,806
Less unamortized bond issuance costs				(7,358)	(7,860)
Unamortized premiums net of discounts				63,722	67,491
Total bonds, loans, notes payable and finance leases				797,579	840,437
Less portion classified as current liabilities				(41,994)	(42,842)
				$755,585	$797,595

10. Long-Term Debt and Revolving Lines of Credit (Continued)

Annual principal maturities of long-term debt for the five fiscal years after September 30, 2021, and the years thereafter, are as follows (in thousands):

	Bonds and Notes	Finance Lease Obligation
2022	$ 36,761	$ 2,449
2023	36,971	1,397
2024	35,611	1,394
2025	36,221	1,382
2026	17,870	1,350
Years thereafter	569,726	1,546
	$733,160	9,518
Less amounts representing interest under finance lease obligations		(1,463)
		$ 8,055

In 1999, the Board of Trustees of MaineHealth adopted a Parent Model Master Trust Indenture (the Indenture), and the Boards of Trustees of MaineHealth, MMC and certain other MaineHealth subsidiaries adopted a System Funding Agreement. The legal name of the corporation then known as MaineHealth is currently known as MaineHealth Services. For ease of reference, the corporation will be referred to as "MaineHealth Services" in this note. Adoption of the Indenture and the System Funding Agreement resulted in the creation of an Obligated Group for the MaineHealth System (the Obligated Group), with certain MaineHealth subsidiaries established as Designated Affiliates of the Obligated Group (the Designated Affiliates). Designated Affiliates have access to lower cost capital and less restrictive debt covenants. MaineHealth Services is the only member of the Obligated Group. Effective with the unification merger described in Note 1, the following Designated Affiliates merged into MMC (renamed MaineHealth as part of the unification merger): Stephens Memorial Hospital Association, Maine Behavioral Healthcare, LincolnHealth and Southern Maine Health Care. Quarry Hill was approved as a new Designated Affiliate. As a result, the Designated Affiliates under the Indenture and the System Funding Agreement as of January 1, 2019 are MaineHealth Services, MaineHealth, LincolnHealth Cove's Edge, Inc., and Quarry Hill. The Designated Affiliates under the Indenture and the System Funding Agreement are indirectly liable for the debt service on the obligations issued under the Indenture for the benefit of any Designated Affiliate. MaineHealth must remain a Designated Affiliate under the Indenture and the System Funding Agreement and has approval authority over any additional MaineHealth subsidiary requesting designation as a Designated Affiliate under the System Funding Agreement. As of September 30, 2021 and 2020, debt issued under the System Funding Agreement was $583,740,000 and $594,025,000, respectively. Debt issued under the Indenture as of September 30, 2021 and 2020 was $572,712,000 and $582,229,000, respectively. In 2019, the Indenture was revised to include a pledge of gross revenues from MaineHealth and MaineHealth Services. As of September 30, 2021 and 2020, $695,566,300 and $728,225,000, respectively, of debt obligations were covered by the pledge of gross revenues.

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

MaineHealth Services subsidiaries that were not Designated Affiliates prior to the unification merger had outstanding debt related to MHHEFA Revenue Bonds and Revenue Refunding Bonds that was not issued under the terms of the Indenture. Under the terms of this debt, these MaineHealth Services subsidiaries were required to maintain deposits with the related bond trustee. Such deposits are included with investments whose use is limited in the consolidated balance sheets. In addition, the terms of this debt also required that these MaineHealth Services subsidiaries satisfy certain measures of financial performance (including a minimum debt service coverage ratio) and other financial covenants as long as the bonds were outstanding. For the year ended September 30, 2020, these measures of financial performance have been suspended. Upon the January 1, 2019 unification merger of these subsidiaries into MaineHealth, which is a Designated Affiliate, the various loan agreements for these outstanding obligations were amended to bring them under the terms of the Indenture and the System Funding Agreement. Mid Coast Hospital, which was not a member of the Obligated Group as of September 30, 2020, was required in accordance with its separate loan agreement with Key Bank to maintain a minimum debt service coverage ratio. Effective January 1, 2021, Mid Coast Hospital merged into MaineHealth, and the loan agreement for this outstanding obligation was amended to bring it under the terms of the Indenture and the System Funding Agreement and all covenants were met.

In July 2020, MHHEFA issued Series 2020 bonds for the amount of $212,700,000, with the proceeds being used to fund a portion of the MMC master facilities project and the construction of an inpatient behavior health unit at Southern Maine Health Care. Of the Series 2020 bonds, $205,213,000 will be used to fund MMC's master facilities project that includes a seven story patient tower consisting of 128 single patient rooms that are both private and universal allowing standard, intermediate and critical care in addition to updated clinical procedure rooms and a 108,000 square foot ambulatory care building at its Scarborough campus. Of the Series 2020 bonds, $7,487,000 will be used to fund the renovation and construction of 42 inpatient behavioral health beds at Southern Maine Health Care's Sanford campus. This debt is secured by the Indenture, the System Funding Agreement and the MaineHealth Gross Revenue Pledge.

In September 2020, MaineHealth advanced the defeasement of the 2011A, 2011C and 2012A MHHEFA tax-exempt bonds with two taxable loans payable to TD Bank. The two TD Bank loans are forward purchase agreements with principal amounts paid to TD Bank by MaineHealth to be held until the MHHEFA bonds can be called, at which time MHHEFA will issue new tax exempt bonds to be purchased by TD Bank at a lower interest cost than the prior bonds. The defeasement of the 2011A and 2011C MHHEFA bonds was financed with a $21,115,000 TD Bank loan with a forward purchase agreement date of July 1, 2021, herein referred to as "Series 2020A". The defeasement of the 2012A MHHEFA bonds was financed with a $15,260,000 TD Bank loan with a forward purchase agreement date of July 1, 2022, herein referred to as "Series 2020B". On April 5, 2021, in an in-kind exchange, the Series 2020A taxable loan was prepaid in full with the MHHEFA Series 2021A tax-exempt bonds purchased by TD Bank, in the amount of $21,115,000. Both the Series 2020B taxable TD Bank loan and the Series 2021A tax-exempt TD Bank direct purchase bonds are secured by the Indenture, the System Funding Agreement and MaineHealth Gross Revenue Pledge.

In July 2018, MHHEFA issued its Series 2018A and 2018B bonds totaling $175,260,000, the proceeds of which are being used to fund a portion of the MMC master facilities project. The project includes the financing, construction, renovation and equipment of 64 new patient rooms, additional visitor parking, a new employee parking garage, and the acquisition and renovation of an office building. This debt was issued under the Indenture and the System Funding Agreement.

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10. Long-Term Debt and Revolving Lines of Credit (Continued)

In August 2018, MHHEFA issued its Series 2018C term bonds totaling $36,735,000 for private placement with TD Bank, N.A., the proceeds of which were used to refinance MMC's outstanding MHHEFA Series 2008A Revenue Bonds. This debt was issued under the Indenture and the System Funding Agreement.

MHHEFA Revenue Bonds, including the Series 2018A, 2018B and 2018C Bonds, are generally secured under a Bond Indenture. These Bond Indentures are contracts among MHHEFA, the Bond Trustee and the bondholders of that series of bonds, and the respective pledges and covenants made therein are for the equal and ratable benefit and security of the bondholders. The Bond Indentures for the Series 2018A, 2018B and 2018C Bonds provide that such bonds shall be special obligations of MHHEFA, payable solely from and secured solely by the payments made by MMC under the respective Bond Indenture, and the funds available in the Bond Fund established under such Bond Indenture.

In January 2015, MHHEFA issued its Series 2014 bonds totaling $85,105,000 for the benefit of MMC and Stephens Memorial Hospital Association. The MMC portion, $79,675,000, was used to finance renovations and equipment for the Bean Building and to refinance a portion of MHHEFA's, Series 2008A bonds totaling $42,760,000. The Stephens Memorial Hospital Association portion, $5,430,000, was used to finance construction of and equipment for a new medical office building. Stephens Memorial Hospital Association, a subsidiary at the time of Western Maine Health Care Corporation, has since been merged into MMC as part of the unification merger. This debt was issued under the Indenture and the System Funding Agreement.

Deferred financing costs of $7,358,000 in 2021 and $7,860,000 in 2020 are reported as a component of long term debt and represent the costs incurred in connection with the issuance of the bonds. These costs are being amortized over the term of the bonds. Amortization expense for the years ended September 30, 2021 and 2020 was $502,000 and $637,000, respectively. The original issue discount/premium is amortized/accreted over the term of the related bonds using the effective interest method.

Effective January 1, 2019, following the unification merger, all existing lines of credit for the merged subsidiaries were terminated and replaced with a single System line of credit in the amount of up to $50,000,000 which expired on June 30, 2020 and renewed to expire on August 31, 2022. In May 2020, an additional $100,000,000 System line of credit was established due to expire in May 2021. All lines of credit were terminated and replaced in fiscal year 2021 with a single $100,000,000 line of credit effective June 22, 2021 and due to expire August 31, 2023.

The line of credit is secured by a MaineHealth gross revenue pledge. There were no amounts outstanding on the lines of credit as of September 30, 2021 and 2020.

11. Leases

The System utilizes operating and finance leases for the use of certain hospitals, medical office buildings, and medical equipment. All lease agreements generally require the System to pay maintenance, repairs, property taxes and insurance costs, which are variable amounts based on actual costs incurred during each applicable period. Such costs are not included in the determination of the right of use (ROU) asset or lease liability. Variable lease cost also includes escalating rent payments that are not fixed at commencement but are based on an index that is determined in future periods over the lease term based on changes in the Consumer Price Index or other measure of cost inflation. Most leases include one or more options to renew the lease at the end of the initial term, with renewal terms that generally extend the lease at the then market rate of rental payment. Certain leases also include an option to buy the underlying asset at or a short time prior to the termination of the lease. All such options are at the System's discretion and are evaluated at the commencement of the lease, with only those that are reasonably certain of exercise included in determining the appropriate lease term.

The following table presents lease-related assets and liabilities at September 30, 2021 and 2020 (in thousands):

	Balance Sheet Classification	2021	2020
Assets:			
Operating leases:	Right of use assets	$160,178	$176,780
Finance leases:	Property, plant and equipment:		
	Buildings	$ 11,211	$ 11,211
	Equipment	6,965	6,716
		18,176	17,927
	Less accumulated depreciation and amortization	(11,029)	(10,776)
	Property, plant and equipment, net	$ 7,147	$ 7,151
Total assets		$167,325	$183,931
Liabilities:			
Current:			
Operating lease liabilities	Current portion of lease obligation	$ 17,406	$ 21,079
Finance lease obligations	Current portion of long-term debt	2,018	2,270
Long-term:			
Operating lease liabilities	Long-term lease obligation	146,366	157,633
Finance lease obligations	Long-term debt	6,037	7,322
Total liabilities		$171,827	$188,304

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11. Leases (Continued)

The components of lease cost and rent expense for the years ended September 30 are as follows (in thousands):

	Statement of Operations Classification	2021	2020
Operating lease expense	Facility and other costs	$ 28,855	$ 28,508
Short-term lease cost	Facility and other costs	6,156	4,956
Finance lease expense:			
Amortization of ROU assets	Depreciation and amortization	$ 2,858	$ 2,247
Interest on finance lease liabilities	Interest expense	577	607

The weighted-average lease terms and discount rates for operating and finance leases are as follows for the years ended September 30:

	2021	2020
Weighted-average remaining lease term:		
Operating leases	20.3 years	19.8 years
Finance leases	5.6 years	5.5 years
Weighted-average discount rate:		
Operating leases	3.4%	3.3%
Financing leases	5.7%	5.8%

Supplemental cash flow and other information related to leases as of and for the years ended September 30 is as follows (in thousands):

	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases (liability reduction)	$21,914	$ 26,727
Operating cash flows from finance leases (fixed payments)	27,267	21,687
Operating cash flows from finance leases (liability reduction)	525	789
Financing cash flows from finance leases	2,406	2,637
Right-of-use assets obtained in exchange for lease obligations:		
Finance lease	895	94
Operating lease	–	205,755

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11. Leases (Continued)

Commitments relating to noncancellable operating and finance leases obligations for each of the next five fiscal years after September 30, 2021, and the years thereafter, are as follows (in thousands):

	Operating Leases	Finance Leases
2022	$ 21,700	$ 2,449
2023	19,512	1,397
2024	17,386	1,394
2025	15,133	1,382
2026	13,933	1,350
Thereafter	157,310	1,546
Total minimum future payments	244,974	9,518
Less imputed interest	(81,202)	(1,463)
Total liabilities	163,772	8,055
Less current portion	(17,406)	(2,018)
Long-term liabilities	$146,366	$ 6,037

12. Self-Insurance Trusts and Reserves

Prior to unification, certain System members were partially self-insured for professional and general liability risks. These entities shared risk above certain amounts with an insurance company for all claims related to the partially self-insured plans. Post-unification, the professional and general liability policy has excess coverage whereby the System is responsible for the first $200,000 of a professional general liability claim; 50% of amounts between $200,000 and $2,000,000; and 25% of amounts over $2,000,000 and up to $7,000,000.

The professional and general liability trust funds of the unified entities have been combined and will be used to pay claims from anywhere in the System with the exception of The Memorial Hospital at North Conway, N.H. who insures its medical malpractice risks on a claims-made basis. In fiscal year 2020, the System maintained separate trust funds for both the professional and general liability insurance. The System funds these trusts based upon actuarial valuations and historical experience. Self-insurance reserves for self-insured unpaid claims and incidents are estimated using actuarial valuations, historical payment patterns, and current trends. Self-insurance reserves are recorded in the period the claim or incident occurs and adjusted in future periods as additional data becomes known. The general liability trust as originally created has met its original purpose and MaineHealth determined in fiscal year 2021 that it was no longer needed. The trust was dissolved in July 2021 and the proceeds were distributed to MaineHealth.

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12. Self-Insurance Trusts and Reserves (Continued)

As of September 30, 2021 and 2020, there are no known claims outstanding, which, in the opinion of management, will be settled for amounts in excess of insurance coverage. As of September 30, 2021 and 2020, an accrual for estimated claims incurred but not reported was recorded. An estimated recovery related to such claims is included in the consolidated financial statements as of September 30, 2021 and 2020.

The System provides health and dental insurance for its employees through a self-insured plan administered by the System. Self-insurance reserves for unpaid claims and incidents are carried at MaineHealth.

With the exception of The Memorial Hospital at North Conway, N.H., the System provides workers compensation insurance for its employees through a self-insured plan administered by MaineHealth. Self-insurance reserves are carried at MaineHealth for unpaid claims and settlements are estimated using actuarial valuations. Self-insurance reserves are recorded in the period the incident occurs and adjusted in future periods as additional data becomes known. The Memorial Hospital at North Conway, N.H. is fully insured through New Hampshire Employers Insurance Company.

13. Retirement Benefits

Defined Benefit Pension Plan

The System sponsors a defined benefit pension plan (the Plan), which was previously sponsored by Maine Medical Center, covering all grandfathered employees that work 750 or more hours in a plan year. Effective January 1, 2014, the Plan was amended to exclude from participation all employees hired on or after January 1, 2014. Such employees are eligible to participate in the defined contribution plan (the MaineHealth 403(b) Retirement Plan). The Plan was also amended effective January 1, 2011, to change the basis of a participant's accrued benefit. Prior to January 1, 2011, accrued benefits were based on the highest five years of final average pay. Effective January 1, 2011, for participants hired on or before December 31, 2009, there is a benefit based on the participant's final average pay through December 31, 2020, and years of service through December 31, 2010. This final average pay benefit is frozen as of December 31, 2020.

For participants currently employed or hired on or after January 1, 2010, but before January 1, 2014, accrued benefits are based on a cash balance formula that became effective January 1, 2011. A participant's cash balance account is increased by an annual cash balance contribution for participants with 750 hours of service, and interest credits in accordance with the terms of the amended Plan Document. The annual cash balance contribution is determined by applying a rate based on age and years of service to the participant's annual compensation. Interest credits are equal to a percentage of the participant's cash balance account on the first day of the Plan year and are credited on the last day of the Plan year prior to payment of the annual cash balance contribution. Except for certain instances, the rate of interest used to determine the interest credit for a Plan year is 5%. Retiring or terminating employees have the option to receive a lump-sum payment, annuity, or transfer to another qualified plan in accordance with the terms of the amended Plan Document.

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13. Retirement Benefits (Continued)

The System's funding policy is to contribute amounts to fund current service cost and to fund over 30 years the estimated accrued benefit cost arising from qualifying service prior to the establishment of the Plan. The assets of the Plan are held in trust and are invested in a diversified portfolio that includes temporary cash investments, marketable equity securities, mutual funds, U.S. Treasury notes, corporate bonds and notes, hedge funds, and other funds.

Defined Benefit Postretirement Medical Plan

As of May 1, 2015, eligible retirees who were enrolled in the Over 65 Retiree Group Companion Plan have transitioned to supplemental retiree health insurance options offered through a private Medicare Exchange engaged by the System and the Companion Plan was curtailed. Transitioned retirees, and certain future retirees, are eligible for an employer contribution to a Health Reimbursement Account (HRA) if they meet certain eligibility requirements. All other eligible System retirees who become Medicare eligible are also eligible to obtain supplemental coverage through the private Medicare Exchange but are not eligible for the employer contribution to the HRA.

Effective January 1, 2016, under age 65 retirees no longer have the option to enroll in the Under 65 Retiree Medical Plan. Retirees enrolled in the plan on or before December 1, 2015 are grandfathered until such time as they age into Medicare coverage at age 65. Grandfathered retirees continue to pay 100% of the cost (with the exception of those retirees enrolled as a result of the Voluntary Early Retirement Window in 2013). These retirees by a special arrangement pay the active employee rate for either three years or until they turn 65 whichever is sooner.

The activity in the Plan and Postretirement Medical Plan using valuation dates of September 30, 2021 and 2020, consists of the following (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Net periodic benefit cost:				
Service cost	$ 33,973	$ 33,318	$ –	$ –
Interest cost	28,806	31,486	105	134
Expected return on plan assets	(50,395)	(46,688)	–	–
Amortization of actuarial loss	38,173	36,304	22	28
Prior service credit	(836)	(1,462)	(193)	(193)
Net periodic benefit cost	$ 49,721	$ 52,958	$ (66)	$ (31)

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13. Retirement Benefits (Continued)

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Change in benefit obligation:				
Benefit obligation, beginning of year	$1,040,877	$ 971,081	$ 3,883	$ 4,238
Service cost	33,973	33,318	–	–
Interest cost	28,806	31,486	105	134
Actuarial (gain) loss	(13,616)	61,502	(245)	(91)
Benefits paid	(69,119)	(49,851)	(374)	(398)
Expenses paid	(5,372)	(6,659)	–	–
Benefit obligation, end of year	1,015,549	1,040,877	3,369	3,883
Change in plan assets:				
Net assets of plan, beginning of year	746,215	652,909	–	–
Actual return on plan assets	126,612	90,516	–	–
Employer contribution	61,170	59,300	374	398
Benefits paid	(69,119)	(49,851)	(374)	(398)
Expenses paid	(5,372)	(6,659)	–	–
Net assets of plan, end of year	859,506	746,215	–	–
Net amount recognized	$ (156,043)	$ (294,662)	$ (3,369)	$ (3,883)

The additional defined benefit pension plan and Postretirement Medical Plan disclosure information for the years ended September 30, 2021 and 2020, is as follows (in thousands):

	Defined Benefit Pension Plan		Postretirement Medical Plan	
	2021	2020	2021	2020
Amounts recognized in the consolidated balance sheets – accrued retirement benefits	$ (156,043)	$ (294,662)	$ (3,369)	$ (3,883)
Additional information – accumulated benefit obligation	(986,452)	(1,011,047)	–	–

Net assets without donor restrictions at September 30, 2021 and 2020, include unrecognized losses of $273,693,000 and $401,699,000, respectively, related to the Plan. Of this amount, $30,015,000 is expected to be recognized in net periodic pension cost in 2022. The aggregate gain in 2021 was primarily due to the improved funded status resulting from the better-than-expected return on assets, and the aggregate loss in 2020 was due to the decrease in the long-term interest rates underlying the discount rate.

13. Retirement Benefits (Continued)

The assumptions of the Plan as of September 30, 2021 and 2020 are as follows:

	2021	2020
Measurement date	September 30	September 30
Census date	January 1	January 1
Used to determine net periodic pension cost:		
Discount rate	2.86%	3.35%
Rate of compensation increase	3.50%	3.50%
Expected long-term rate of return on plan assets	7.00%	7.00%
Used to determine benefit obligation:		
Discount rate	2.98%	2.86%
Rate of compensation increase	3.50%	3.50%

The expected long-term rate of return on plan assets for the Plan reflects the System's estimate of future investment returns (expressed as an annual percentage) taking into account the allocation of plan assets among different investment classes and long-term expectations of future returns on each class.

The targeted allocation for the Plan investments are: debt securities – 30%, U.S. equity securities – 22.5%, international equity securities – 17.5%, emerging market equity securities – 5%, natural resources – 5%, and alternative investments – 20%. The Plan's investments as of September 30, 2021 and 2020 are disclosed in Note 8.

The Plan's overall financial objective is to provide sufficient assets to satisfy the retirement benefit requirements of the Plan's participants. This objective is to be met through a combination of contributions to the Plan and investment returns. The long-term investment objective for the Plan is to attain a total return (net of investment management fees) of at least 5% per year in excess of the rate of inflation measured by the Consumer Price Index. The nature and duration of benefit obligations, along with assumptions concerning asset class returns and return correlations, are considered when determining an appropriate asset allocation to achieve the investment objectives.

Investment policies and strategies governing the assets of the Plan are designed to achieve the financial objectives within prudent risk parameters. Risk management practices include the use of external investment managers, the maintenance of a portfolio diversified by asset class, investment approach, and security holdings, and the maintenance of sufficient liquidity to meet benefit obligations as they come due.

The medical inflation assumption used for measurement purposes in the per capita cost of covered health care benefits for the Postretirement Medical Plan was 6.5% annual rate of increase respectively, for the years ended September 30, 2021 and 2020. This rate was assumed to gradually decrease to 4.5% by 2023 and remain at that level thereafter.

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13. Retirement Benefits (Continued)

Future benefits are expected to be paid as follows at September 30, 2021 (in thousands):

	Defined Benefit Pension Plan	Postretirement Medical Plan (net of Retiree Contributions)
Years ended September 30:		
2022	$ 70,102	$ 387
2023	68,970	372
2024	71,456	349
2025	70,393	326
2026	72,830	303
2027 – 2031	356,454	1,185

The estimated expected contribution to be made during the year ending September 30, 2022 is $40,587,000.

Defined Contribution Pension Plans

The System sponsors the MaineHealth 403(b) Retirement Plan, which benefits substantially all of their employees. This plan assumed the Maine Medical Center 403(b) Retirement Plan and subsequently over the course of several years merged in the various 403(b) plans of the various subsidiaries. Amounts expensed under these plans were $49,127,000 and $39,970,000 in 2021 and 2020, respectively. The Plan is a MaineHealth sponsored plan but each local health system contributes its own employer contribution level for its local employees.

Nonqualified Deferred Compensation Plan

The System offers a 457(b) nonqualified deferred compensation plan to certain eligible employees. Eligible employees may elect up to the maximum dollar amount as defined by Section 402(g) of the Internal Revenue Service code. The plan is funded solely by employee contributions that are invested in various marketable securities at the direction of the employees. These investments are classified as Level 1 and Level 2 investments which are valued using quoted prices for active markets of identical assets. The assets of the plan are the legal assets of the System until they are distributed to participants, and therefore the plan assets and corresponding liability are reported as other assets and accrued retirement benefits in the accompanying consolidated balance sheet. As of September 30, 2021 and 2020 the balances of the plan were $137,304,000 and $113,328,000, respectively.

14. Net Assets

Resources are classified for reporting purposes as net assets without donor restrictions and net assets with donor restrictions, according to the absence or existence of donor-imposed restrictions. Resources arising from the results of operations or assets set aside by the Board of Trustees are not considered to be donor restricted. Net assets with donor restrictions represent funds including contributions and accumulated investment returns, whose use has been restricted by donors to a specific period or purpose or that have been restricted by donors to be maintained in perpetuity to provide a permanent source of income. Generally, the donors of these donor restricted assets permit the use of part of the income earned on related investments for specific purposes. Net assets are as follows at September 30 (In thousands):

	2021	2020
Without donor restrictions	$2,232,624	$1,774,871
With donor restrictions:		
Perpetual in nature	120,374	106,292
Purpose restricted	185,784	165,089
Time restricted	2,597	2,373
Net assets	$2,541,379	$2,048,625

Endowment Funds

The System's endowment consists of funds established for a variety of purposes. For the purposes of this disclosure, endowment funds include donor-restricted endowment funds. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

The System has interpreted state law as requiring realized and unrealized gains on net assets with donor restrictions to be retained in a net assets with donor restrictions classification until appropriated by the Board and expended. State law allows the Board to appropriate so much of the net appreciation of net assets with donor restrictions as is prudent considering the System's long-and short-term needs, present and anticipated financial requirements, and expected total return on its investments, price level trends, and general economic conditions.

As a result of this interpretation, the System classifies as net assets with donor restrictions (a) the original value of the gifts donated to the endowment when explicit donor stipulations requiring permanent maintenance of the historical fair value are present and (b) the original value of the subsequent gifts to the endowment when explicit donor stipulations requiring maintenance of the historical fair value are present. The remaining portion of the donor-restricted endowment fund composed of accumulated gains not required to be maintained in perpetuity is classified as net assets with donor restrictions until those amounts are appropriated for expenditure in a manner consistent with the donor's stipulations. The System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: duration and preservation of fund, purposes of the donor-restricted endowment funds, general economic conditions, the possible effect of inflation and deflation, the expected total return from income and the appreciation of investments, other resources of the System, and the investment policies of the System.

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14. Net Assets (Continued)

Endowment Investment Return Objectives

The System has adopted investment policies for endowment assets that attempt to provide a predictable stream of funding to the programs supported by its endowment while seeking to maintain the purchasing power of the endowment assets. Endowment assets include those assets of donor-restricted funds that the System must hold in perpetuity or for a donor-specified period(s) as well as board-designated funds. Under this policy, the endowment assets are invested in a manner to attain a total return (net of investment management fees) of at least 5.0% per year in excess of inflation, measured by the Consumer Price Index. To satisfy its long-term rate of return objectives, the System targets a diversified asset allocation that places a greater emphasis on equity-based investments within prudent risk constraints.

Endowment Investment Asset Composition

The following is a summary of the endowment asset composition by type of fund at September 30, 2021 and 2020, and the changes therein for the years then ended (in thousands):

	With Donor Restrictions
Endowment investment, end of year, September 30, 2019	$109,500
Investment return, net	15,232
Contributions	533
Contribution of net assets from acquired affiliates	15,073
Changes in interest in perpetual trust	72
Net assets transferred	174
Appropriation of endowment assets for expenditure	(7,256)
Endowment investment, end of year, September 30, 2020	133,328
Investment return, net	27,974
Contributions	1,994
Changes in interest in perpetual trust	(419)
Appropriation of endowment assets for expenditure	(6,658)
Endowment investment, end of year, September 30, 2021	$156,219

Funds With Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor requires the System to retain as a fund of perpetual duration.

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15. Functional Expenses

The System provides health care services through its acute care, specialty care, and ambulatory care facilities. Expenses relating to providing these services for the years ended September 30, 2021 and 2020, are as follows (in thousands):

	Program Services		Supporting Activities	
	Healthcare Services	Research	Management and General	Total Expenses
September 30, 2021				
Salaries, wages and fringe benefits	$1,385,485	$18,892	$621,292	$2,025,669
Patient care supplies	542,624	1,833	19,775	564,232
Professional fees and purchased services	183,398	6,673	130,865	320,936
Depreciation and amortization	121,091	1,259	39,295	161,645
Other operating expenses	123,704	695	64,008	188,407
Interest expense	11,953	–	6,701	18,654
	$2,368,255	$29,352	$881,936	$3,279,543
September 30, 2020				
Salaries, wages and fringe benefits	$1,227,977	$17,157	$595,071	$1,840,205
Patient care supplies	443,745	1,500	17,216	462,461
Professional fees and purchased services	146,334	8,322	106,885	261,541
Depreciation and amortization	114,975	1,324	37,301	153,600
Other operating expenses	101,394	636	67,534	169,564
Interest expense	10,034	–	7,686	17,720
	$2,044,459	$28,939	$831,693	$2,905,091

16. Contingencies

The System is subject to complaints, claims, and litigation, which have risen in the normal course of business. In addition, the System is subject to compliance with laws and regulations of various governmental agencies. Recently, governmental review of compliance with these laws and regulations has increased resulting in fines and penalties for noncompliance by individual health care providers. Compliance with these laws and regulations is subject to future government review, interpretation, or actions, which are unknown and un-asserted at this time.

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SUPPLEMENTARY INFORMATION

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MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

Year Ended September 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development:				
Direct Awards – National Institutes of Health – Research and Development				
Environmental Chemicals, Adiposity, and Bone Accrual Across Adolescence	93.113		$ 55,059	$ 645,928
Congenital Abnormalities Resulting From Fetal Thyrotoxicosis	93.121		–	121,073
Epigenetic Influence on Thyroid Hormone Action in the Brain and on Behavior	93.242		–	355,268
Exploring Affect Variability, Symptoms, and Social Context in Psychotic-Spectrum Youth	93.242		5,577	5,577
Sciex TripleTOF 6600+ System Mass Spectrometer and Dedicated in-line EKSPERT nanoLC 425 Liquid Chromatographic System	93.351		–	541,368
COVID-19: A Period Seroprevalence (SARS-CoV-2) Survey in MHCCN Cancer Healthcare Workers (HCWs) Providing Patient Care During the Height of the Outbreak: A Registry Study	93.394		–	57,602
Defining the Roles of Bone Marrow Adipocytes and FABP4/5 Signaling in Multiple Myeloma Drug Resistance	93.395		–	385,412
Role of the Macrophage Derived XL313 Epitope In Angiogenesis and Tumor Growth	93.396		–	328,189
Lipid Metabolism-Driven Drug Resistance in Multiple Myeloma	93.398		–	12,943
MaineHealth Cancer Care Network (MHCCN) and NCORP Activities Across the Lifespan	93.399		92,662	1,022,411
Rab27a Functions in the Vascular Microenvironment	93.837		–	5,201
Effect of CTHRC1 on Endothelial Cell Survival After Acute Ischemia	93.837		–	513,997
Molecular Determinants of the Fate of Human Heart Mesenchymal Progenitor Cells	93.837		–	527,425
Regulation of Arterial Phenotype By Perivascular Adipose Tissue in Cardiometabolic Disease	93.837		–	355,725
Functional Role of CD34 Family in Hematopoiesis	93.839		–	39,980
Neuregulin Signaling in Myeloid Cells	93.839		–	254,629
The Myokine Irisin Modulates Bone Resorption via Stimulation of Osteoclastogenesis	93.846		–	61,718
TRPM8 is a Novel Regulator of Bone Homeostasis Through Neural and Cell-Autonomous Mechanisms	93.846		–	66,717
A Novel Cell-Autonomous Role for Adrenergic Receptor Signaling in Osteoclasts	93.846		–	54,224
Mesoderm Specific Transcript and Adipose Tissue Expansion	93.847		–	465,445
Transgenerational Epigenetic Programming of the Thyroid Axis	93.847		–	471,031
Interdisciplinary Study of Marrow Adiposity, Mineral Metabolism & Energy Balance	93.847		22,375	866,802
The Lipidomics of Adipose Tissue Thermogenesis	93.847		–	17,387
miR-27 Mediated Regulation of Mitochondrial Function in Thermogenic Adipocytes	93,847		–	4,908
Northern New England Clinical and Translational Research Network	93.859		1,676,182	3,496,358
Center of Biomedical Research Excellence in Acute Care Research and Rural Disparities	93.859		8,600	981,712
Phase I COBRE in Mesenchymal and Neural Regulation of Metabolic Networks	93.859		47,957	2,105,065
Understanding Factors Influencing COVID-19 Testing and Vaccination in Immigrant Low-income and Homeless Populations and Testing Targeted Interventions	93.859		–	22,299
Circadian Phase, Sleep, and Challenging Behavior in Autism Spectrum Disorder	93.865		–	94,141
Transmission Distortion Depending on Sperm-Egg Interactions at Fertilization	93.865		43,444	76,751
M-Palliative Care Link: Improving Symptom Control and Information Exchange Among Specialists and Local Health Workers Treating Late Stage Tanzanian Cancer Patients	93.989		–	28,197
Total Direct Awards – National Institutes of Health – Research and Development			1,951,856	13,985,483

MAINEHEALTH SYSTEM
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SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development:				
Arsenic Related Cystic Fibrosis – The Children's Hospital Corporation d/b/a Boston Children's Hospital	93.113	GENFD0001830013	$ -	$ 12,010
Arsenic Related Cystic Fibrosis – The Children's Hospital Corporation d/b/a Boston Children's Hospital	93.113	GENFD0002016479	-	27,342
The National Drug Abuse Clinical Trials Network: New England Consortium Node Ctn-0099 – Yale University	93.279	GR109725 (CON-80002432)	-	340,048
Genetic Modifiers of Chrna5 Deletion in Mice: Role in Nicotine Behaviors Modulated by the Medial Habenula-IPN Pathway – Regents of the University of Colorado, a Body Corporate, Acting on Behalf of the University of Colorado Boulder	93.279	1558686	-	5,445
Genetic Modifiers of Chrna5 Deletion in Mice: Role in Nicotine Behaviors Modulated by the Medial Habenula-IPN Pathway – Regents of the University of Colorado, a Body Corporate, Acting on Behalf of the University of Colorado Boulder	93.279	1560122	-	13,831
Tufts Clinical and Translational Science Institute Pilot – Understanding the Protective Effects of Tranexamic Acid in Trauma: Beyond Anti-Fibrinolysis – Tufts University	93.350	102188-00001/Joseph_Rappold_NH9003	-	27,199
Tufts Clinical and Translational Sciences Institute – Tufts University	93.350	102188-00001/Neil_Korsen_NH9004	-	12,493
Tufts Clinical and Translational Sciences Institute – Tufts University	93.350	102188-00052:NH9065_Thakarar	-	12,876
Tufts CTSA Graduate Program – Tufts University	93.350	102187-00004:MH0007_Fitzgerald	-	11,778
CTSA Institutional Mentored Career Development Program (KL2): Relation of Changes in Kidney Function With Cardiac Hemodynamics and Neurohormonal Activity in Acute Heart Failure - Tufts University	93.350	102186-00010:NH9057_Anderson	-	11,701
Niclosamide Activity in COVID-19 - Tufts University	93.350	NIH152_Fairfield	-	15,780
SIMPRO Research Center: Integration and Implementation of PROs for Symptom Management in Oncology Practice – Dana-Farber Cancer Institute, Inc.	93.353	1204501	-	(2,346)
SIMPRO Research Center: Integration and Implementation of PROs for Symptom Management in Oncology Practice – Dana-Farber Cancer Institute, Inc.	93.353	1204503	-	101,435
SIMPRO Research Center: Integration and Implementation of PROs for Symptom Management in Oncology Practice – Dana-Farber Cancer Institute, Inc.	93.353	1204504	-	37,211
Optimizing Tobacco Treatment for Smokers Seeking Lung Cancer Screening – Memorial Sloan Kettering Cancer Center	93.393	226808	-	(2,500)
Per Case Reimbursement: NIH National Clinical Trials Network (NCTN) Grant – Children's Hospital of Philadelphia	93.395	9500080215-12c	-	500
NRG Oncology Network Group Operations Center - NRG Oncology Foundation, Inc.	93.395	Not identified	-	2,752
Cancer Treatment Research - The Children's Hospital of Philadelphia on Behalf of The Children's Oncology Group	93.395	Not identified	-	15,466
COG NCTN Network Group Operations Center - Public Health Institute	93.395	AR03255	-	9,022

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development (Continued):				
Advancing Cardiothoracic Surgical Trials in Rural Health Populations – Dartmouth-Hitchcock Clinic	93.837	GC10197-00-01	$ –	$ 64,037
Advancing Cardiothoracic Surgical Trials in Rural Health Populations - Dartmouth Hitchcock	93.837	GC10197-00-01	–	146,426
Cardiovascular Inflammation Reduction Trial (CIRT) – Brigham & Women's Hospital, Inc.	93.837	PS #107223	–	1,448
Collaborative Learning to Improve Intensive Care Unit Developmental Care in Congenital Heart Disease – New England Research Institutes, Inc.	93.837	4752A17B-E104-479B-B3FC-19E8E8009EDA	21	9,083
Cardiovascular Diseases Research - Seattle Children's Hospital	93.837	11301SUB	–	1,805
Cardiovascular Diseases Research – New England Research Institutes, Inc.	93.837	Not identified	–	1,063
The ACCESS Trial - CCC - Regents of the University of Minnesota	93.837	N005339731	–	5,488
Network for Cardiothoracic Surgical Investigations in Cardiovascular Medicine: Anticoagulation for New-Onset Post-Operative Atrial Fibrillation After CABG - Icahn School of Medicine at Mount Sinai	93.837	0255-A343-4605	–	15,552
1/2 ICECAP: Influence of Cooling duration on Efficacy in Cardiac Arrest Patients - Tufts Medical Center, Inc.	93.837	Not identified	–	27,287
Data Coordinating Center for the Pediatric Heart Network - New England Research Institutes, Inc.	93.837	Not identified	13,513	13,513
Outcomes Related To COVID-19 Treated With Hydroxychloroquine Among In-Patients With Symptomatic Disease (ORCHID) - Baystate Medical Center, Inc.	93.838	20-145	–	13,127
Vitamin D to Improve Outcomes by Leveraging Early Treatment (VIOLET) – Baystate Medical Center	93.838	MMC 17096	–	77
Acute Lung Injury Group New England Program to Support PETAL Network Research (PETAL Core) - Baystate Medical Center, Inc.	93.838	14159-2	–	11,519
OPTIMIZing Treatment for Early Pseudomonas Aeruginosa Infection in Cystic Fibrosis: The OPTIMIZE Multicenter Randomized Trial - Seattle Children's Hospital	93.838	10986SUB	–	1,040
Biology and Longitudinal Epidemiology of COVID-19 Observational Study, BLUE CORAL - Baystate Medical Center, Inc.	93.838	20-231	–	59,324
Post Acute Sequelae of SARS-COV-2 Infection Initiative - NYU Grossman School of Medicine	93.838	Not identified	–	9,843
Antithrombotic Therapy to Ameliorate Complications of COVID-19 (ATTACC), in Collaboration with Accelerating COVID-19 and Vaccines (ACTIV-4) – The University of Manitoba	93.838	Not identified	–	269
Dissemination and Implementation of the Bright Bodies Intervention for Childhood Obesity - Yale University	93.840	GR109183 (CON-80002348)	–	82,315
Genetic Analysis of Bone Strength – The Rector and Visitors of the University of Virginia	93.846	GM10302. PO#2169290	–	22,654
Mechanism of Action of PTH: New Signaling Components That Regulate Bone Formation and Bone Marrow Fat – President and Fellows of Harvard	93.846	158299.5113827.0002	–	88,826
Diabetes Trialnet Study Group – University of South Florida	93.847	1277	–	(134)
PTH Resistance and Marrow Adipogenesis – President and Fellows of Harvard College on Behalf of Harvard Medical School	93.847	158279.5103524.0002	–	29,333

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Department of Health and Human Services – Research and Development (Continued):				
Pass-Through Awards – National Institutes of Health – Research and Development (Continued):				
Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial – Hemodynamics (CREST-H) – Mayo Clinic Jacksonville	93.853	MAI-232483-06	$ -	$ 615
Carotid Revascularization and Medical Management for Asymptomatic Carotid Stenosis Trial (CREST-2) – Mayo Clinic Jacksonville	93.853	MAI-187276-01	-	30,528
Clinical Study: Brain Oxygen Optimization in Severe TBI Phase -3 (BOOST-3) Trial – University of Michigan	93.853	SUBK11612CSPR-002	-	37,871
COVID-19: COVID-C3PO: Clinical Trial of COVID-19 Convalescent Plasma in Outpatients (C3PO) – Tufts Medical Center, Inc.	93.853	Not identified	-	50,052
PREcision Care In Cardiac ArrEst - ICECAP (PRECICECAP) - The Leland Stanford Junior University	93.853	62563991-179030	-	26,271
Emergence of Tick Borne Encephalitis in North America – Tufts University	93.855	102222-00001 / NIH010	-	61,331
Emergence of Tick Borne Encephalitis in North America – Tufts University	93.855	102222-00002 / NIH062	-	21,638
Novel Diagnostics for Early Lyme Disease – MicroBplex, Inc.	93.855	AI1344543	-	1,849
Retrotransposon Assay for Tick Host Bloodmeal Identification – Tufts University	93.855	102406-00001 / NIH032	-	7,437
Retrotransposon Assay for Tick Host Bloodmeal Identification – Tufts University	93.855	NIH032	-	89,658
Biomedical Research and Research Training West Virginia Clinical and Translational Science Institute: Improving Health through Partnerships and Transformative Research - West Virginia University Research Corporation	93.859	12-303G-MMC	-	202,060
DRIVEN: Accelerating Medical Equipment Entrepreneurship in the Northeast – Celdara Medical, LLC	93.859	MMC_DRIVEN	-	64,157
Physiological Mechanisms of Action Relating to Immediate and Long-Term Therapeutic Horseback Riding Intervention Effects in a Psychiatric Population of Youth With Autism Spectrum Disorder – Regents of the University of Colorado	93.865	FY20.557.002	-	115,006
Behavioral and Physiological Assessment of Adolescent and Therapy Dog Interactions - Tufts University	93.865	NH0009	-	1,035
Beta1-Selective Blockade for Prevention of Postmenopausal Bone Loss: A Randomized Controlled Trial - Mayo Clinic	93.866	MAI-277060/PO #67752049	-	162,093
Causes and Consequences of Healthcare Efficiency - Trustees of Dartmouth College	93.866	R1344	-	12,381
FSH – An Aging Hormone? – Icahn School of Medicine at Mount Sinai	93.866	0255-B452-4609	-	149,356
FSH – An Aging Hormone? – Icahn School of Medicine at Mount Sinai	93.866	0255-B454-4609	-	143,551
FSH – An Aging Hormone? – Icahn School of Medicine at Mount Sinai	93.866	0255-B457-4609	-	(2,395)
Medical Library Assistance - University of Massachusetts, Worcester, National Network of Libraries of Medicine, New England Region	93.879	HHSN276201100010C	-	1,327
Medical Library Assistance - University of Massachusetts, Worcester, National Network of Libraries of Medicine, New England Region	93.879	Not identified	-	156
Regional Medical Libraries For The Network Of The National Library Of Medicine: Region 7 & Nphco; Medical Library Assistance - University of Massachusetts, Worcester, National Network of Libraries of Medicine, New England Region	93.879	Not identified	-	2,356
Total Pass-Through Awards – National Institutes of Health – Research and Development			13,534	2,434,271
Total National Institutes of Health – Research and Development			1,965,390	16,419,754

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Centers for Disease Control and Prevention – Research and Development:				
Pass-Through Awards:				
State of New Hampshire Poison Control Center Services - State of New Hampshire	93.069	177129-B003	$ –	$ 7,874
State of New Hampshire Poison Control Center Services - State of New Hampshire	93.070	177129-B004	–	3,149
Community Counts: Public Health Surveillance for Bleeding Disorders – Children's Hospital Corporation dba Boston Children's Hospital	93.080	GENFD0001937079	–	22,389
Community Counts: Public Health Surveillance for Bleeding Disorders – Children's Hospital Corporation dba Boston Children's Hospital	93.080	GENFD0001761969	–	270
Health Promotion and Disease Prevention Research Center - Trustees of Dartmouth College	93.135	1613R734	–	2,101
National State Based Tobacco Control Programs - State of Maine	93.305	CD0-20-4415 B	–	17,992
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) COVID-19 Specimen Collection and Testing - State of Maine	93.323	CD3-21-2201	–	40,000
Maine's 2019 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Diseases Application - State of Maine	93.323	CD4-21-2246	–	40,000
Maine's 2019 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Diseases Application - State of Maine	93.323	CD2-21-2204	–	20,000
Maine's 2019 Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Diseases Application - State of Maine	93.323	CD0-21-5170	–	6,218
Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases - State of New Hampshire	93.323	SS-2021-DPHS-04-HOSPI-I 2)	–	100,558
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) - State of Maine	93.323	CD2-21-2203	–	10,000
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC), Maine Epidemiology & Laboratory Capacity - State of Maine	93.323	CD0-19-5170D	–	(1,416)
National and State Tobacco Control Program - State of Maine	93.387	CD0-20-4415 B	–	1,644
National Center for Research Resources - State of Maine	93.389	CD0-19-4499 G	–	12,263
Medical Assistance Program/Administration - MaineHealth/Poison Control - State of Vermont	93.778	03420 - 09070	–	8,584
Title XIX Medical Assistance Payments - State of Maine	93.778	CD0-19-4499 C	–	6
Total Centers for Disease Control and Prevention – Research and Development			–	291,632
Department of Defense– Research and Development:				
U.S. Army Medical Command – Research and Development:				
Direct Awards:				
Predicting Situational Onset of Aggression in Minimally Verbal Youth with Autism Using Biosensor Data and Machine Learning Algorithms	12.420		–	96,806
A Prospective, Randomized Investigation of Resuscitative Asanguinous Coagulation Enhanced Albumin (RASCAL) in Trauma	12.420		–	85,976
Use of Tranexamic Acid to Reduce Tissue Edema and Prevent Burn Wound Conversion	12.420		–	144,350
Total Direct Awards – U.S. Army Medical Command – Research and Development				327,132
Pass-through Awards				
Biomarkers in the Brain Oxygen Optimization in Severe TBI Trial (Bio-BOOST) - Regents of the University of Michigan	12.420	SUBK00013509	–	5,336
Total Department of Defense– Research and Development			–	332,468
Total Research and Development Cluster			1,965,390	17,043,854

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Medicaid Cluster:				
Centers for Medicare and Medicaid Services:				
Pass-through Awards:				
Statewide Tobacco Dependence Treatment Initiative – State of Maine	93.777	CDO-19-4499	$ -	$ 31,272
Medical Assistance Program - Western Maine Community Action, Inc.	93.778	10A 20201028*1331	-	26,327
MaineHealth/Poison Control – State of Vermont	93.778	03420-08169	-	96,063
Total Medicaid Cluster			-	153,662
Department of Health and Human Services – 477 Cluster:				
Administration for Children and Families Pass-through Awards:				
Temporary Assistance for Needy Families - Maine Youth Action Network (A program of the Opportunity Alliance)	93.558	Not Identified	-	83
Temporary Assistance for Needy Families - The Opportunity Alliance	93.558	Not Identified	-	99,299
Temporary Assistance for Needy Families - Maine Children's Trust	93.558	SUB CFS-19-1601B	-	81,985
Total 477 Cluster			-	181,367
United States Department of Agriculture – SNAP Cluster				
Unite States Department of Agriculture Pass-through Awards:				
Supplemental Nutrition Assistance Program - University of New England	10.561	29032A-20	-	79,964
Supplemental Nutrition Assistance Program Nutrition Education (SNAP-Ed) – University of New England	10.561	29032A-77	-	(1)
Supplemental Nutrition Assistance Program Nutrition Education (SNAP-Ed) – University of New England	10.561	29032A-83	-	(45)
Supplemental Nutrition Assistance Program - University of New England	10.561	29032D-21	-	148,681
Supplemental Nutrition Assistance Program - University of New England	10.561	29032D-26	-	47,067
Supplemental Nutrition Assistance Program - University of New England	10.561	29032D-29	-	122,409
Total SNAP Cluster			-	398,075

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Department of Health and Human Services – CARES Act				
Direct Awards:				
COVID-19: CARES Funding for Poison Centers	93.253		$ -	$ 4,429
COVID-19: HRSA Claims Reimbursement for the Uninsured Program and the COVID-19 Coverage Assistance Fund	93.461		-	58,806
COVID-19: HRSA Provider Relief Fund	93.498		-	99,222,835*
COVID-19: HRSA Testing and Mitigation for Rural Health Clinics	93.697		-	49,461
Total Direct Awards			-	99,335,531
Pass-through Awards:				
COVID-19: Area Health Education Centers Program COVID - University of New England	93.107	23022-03	-	11,546
COVID-19: Model State Supported AHEC Program – University of New England	93.107	23004D-04	-	140,357
COVID-19: Small Rural Hospital Improvement Grant Program - State of New Hampshire	93.301	Not identified	-	80,218
COVID-19: Small Rural Hospital Improvement Grant Program - State of Maine	93.301	CD0-20-2233	-	40,000
COVID-19: Small Rural Hospital Improvement Grant Program - State of Maine	93.301	CD0-20-2244	-	40,000
COVID-19: Small Rural Hospital Improvement Grant Program - State of Maine	93.301	CD0-20-2243	-	40,000
COVID-19: Swab and Send Specimen Collections - State of Maine	93.323	CDO-21-5452	-	152,730
COVID-19: SeniorsPlus 2021 CARES ACT mini grant - Seniors Plus	93.044	Not Identified	-	(1,601)
COVID-19: National Bioterrorism Hospital Preparedness Program - COVID-19 Program - Maine Hospital Association	93.889	Not Identified	-	437,212
Total Pass-through Awards			-	940,462
Total CARES Act – Department of Health and Human Services			-	100,275,993
Department of the Treasury – CARES Act:				
Pass-through Awards:				
COVID-19: Corona Virus Relief Fund – State of New Hampshire	21.019	Not Identified	-	15,246*
COVID-19: Corona Virus Relief Fund – Northern Maine Development Commission	21.019	Not Identified	-	4,168,249*
COVID-19: Corona Virus Relief Fund – Eastern Maine Development Corporation	21.019	Not Identified	-	1,052,314*
			-	5,235,809
Federal Communications Commission:				
Direct Awards:				
COVID-19 Telehealth Program	32.006		-	84,110
Total CARES Act – Federal Communications Commission			-	84,110

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs:				
Centers for Disease Control and Prevention – Other Programs:				
Direct Awards				
Drug-Free Communities Support Program Grants	93.276		$ –	$ 9,932
Pass-Through Awards:				
Me Pharmaceutical Cache, Consulting & Phone Line - State of Maine	93.069	CD0-21-1319	–	54,644
State of New Hampshire Poison Control Center Services - State of New Hampshire	93.069	RFP-2019-DPHS-01-POISO-01-A01	–	23,862
Public Health Emergency Preparedness - State of Maine	93.069	CD0-21-1319	–	17,231
State of New Hampshire Poison Control Center Services - State of New Hampshire	93.070	RFP-2019-DPHS-01-POISO-01-A01	–	9,545
Me Pharmaceutical Cache, Consulting & Phone Line - State of Maine	93.074	CD0-21-1319	–	60,715
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements - State of Maine	93.074	CD0-21-1319	–	19,146
National State Based Tobacco Control Programs - State of Maine	93.305	CD0-18-4415	–	23,110
National and State Tobacco Control Programs - State of Maine	93.387	CD0-20-4418	–	2,112
COVID Response Assistance - Community Vaccination Director Federal Grant Title: Prevention and Public Health Fund: Capacity Building Assistance to Strengthen Public Health Immunization Infrastructure and Performance - State of Maine	93.539	CDO-21-5255	–	73,454
Me Pharmaceutical Cache, Consulting & Phone Line - State of Maine	93.889	CD0-21-1319	–	6,072
National Bioterrorism Hospital Preparedness Program - State of Maine	93.889	CD0-21-1319	–	1,915
Total Centers for Disease Control and Prevention Other Programs			–	301,738
Health Resources and Services Administration				
Direct Awards:				
Local Community-Based Workforce to Increase COVID-19 Vaccine Access	93.011		–	53,367
Preventive Medicine Residencies	93.117		87,275	463,751
Rural Residency Planning and Development Program	93.155		–	104,113
Telehealth Network Grant Program	93.211		–	193,984
Poison Control Stabilization and Enhancement Program	93.253		–	230,279
Rural Health Care Services Outreach Grant Program	93.912		–	41,155
Rural Communities Opioid Response (Planning)	93.912		4,800	105,185
Rural Communities Opioid Response-Implementation	93.912		106,293	668,234
Total Direct Awards			198,368	1,860,068

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Department of Health and Human Services – Other Programs (Continued):				
Health Resources and Services Administration (Continued):				
Pass-through Awards:				
Hemophilia Treatment Centers (SPRANS) - Icahn School of Medicine at Mount Sinai	93.110	0253-6540-4609	$ –	$ 6,243
Hemophilia Treatment Centers (SPRANS) - Icahn School of Medicine at Mount Sinai	93.110	0253-6549-4609	–	14,313
Leadership Education in Neurodevelopmental and Related Disorders Training Program - University of New England	93.110	230065C-11	–	3,710
Leadership Education in Neurodevelopmental and Related Disorders Training Program - University of New England	93.110	23065B-08	–	5,619
Pediatric Mental Health Care Access - State of Maine	93.110	CD0-20-4221	–	173,699
Maternal and Child Health Federal Consolidated Programs- State of Maine	93.110	CD0-22-4221	–	39,715
Emergency Medical Services for Children - State of Maine	93.127	CT-16A-20190610*3791	–	31,406
AIDS Education and Training Centers Program - University of Massachusetts, Worcester	93.145	OSP29994-05	–	53,118
Poison Control Stabilization and Enhancement Program - University of Vermont Medical Center	93.253	Not identified	–	59,434
Maternal, Infant and Early Childhood Home Visiting Grant Program – Maine Children's Trust	93.870	Sub CDO-21-4130	–	298,839
Primary Care Training and Enhancement - University of New England	93.884	Not identified	–	803
Rural Communities Opioid Response-Implementation - Penobscot Community Health Center, Inc.	93.912	GA1RG33533	–	4,369
Geriatrics Workforce Enhancement Program - University of New England	93.969	23015-092	–	16,600
Geriatrics Workforce Enhancement Program - University of New England	93.969	23015A-021	–	58,812
Maternal and Child Health Services Block Grants to States - State of Maine	93.994	CD0-21-4282	–	23,154
Maternal and Child Health Block Grants to States - State of Maine	93.994	CD0-21-4282	–	107,167
Total Pass-through Awards			–	897,001
Total Health Resources and Services Administration			198,368	2,757,069
Substance Abuse and Mental Health Services Administration				
Direct Awards:				
Project REACH (Recovery, Engagement, Acceptance, Compassion, Hope)	93.243		–	437,778
Franklin County Maine Rural Emergency Medical Services Training Project	93.243		–	182,648
Mid Coast Maine Mental Health Awareness Training Program for Schools and Community	93.243		–	53,153
Project STOP	93.243		–	39,464
Expanding EMS Recruitment and Training in Franklin County, ME	93.243		–	1,515
Southern Midcoast Communities for Prevention: Preventing Underage Substance Use and Promoting Community, Youth and Family Assets	93.276		–	51,191
Total Direct Awards			–	765,749

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Department of Health and Human Services – Other Programs (Continued):				
Substance Abuse and Mental Health Services Administration (Continued):				
Pass-through Awards:				
Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (SED) - State of Maine	93.104	CBH-21-7004A	$ –	$ 27,113
Empower ME - Supporting All Maine Children & Families to Live Safe, Stable, Happy, and Healthy Lives - State of Maine	93.104	CBH-21-7005	–	30,801
Point of Service Maintenance and Enhancement Awards - University of New England	93.107	23004C-07	–	9,804
Statewide Substance Use Prevention Services - University of New England	93.243	29048A-07	–	(7,721)
Statewide Substance Use Prevention Services - University of New England	93.243	29048A-11	–	(1,871)
Statewide Substance Use Prevention Services - University of New England	93.243	29048B-07	–	17,453
Statewide Substance Use Prevention Services - University of New England	93.243	29048B-11	–	35,798
Substance Abuse and Mental Health Services Projects of Regional and National Significance - University of New England	93.243	29048B-14	–	22,846
Statewide Substance Use Prevention Services - University of New England	93.243	29048B-16	–	16,235
Opioid STR – State of Maine	93.788	29048B-07	–	12,419
Block Grants for Prevention and Treatment of Substance Abuse – University of New England	93.788	29048B-11	–	2,549
Opioid STR - University of New England	93.788	29048B-14	–	24,093
Opioid STR - University of New England	93.788	29048B-16	–	1,558
Community Employment Services - State of Maine	93.788	MH4-20-009	–	164,021
Opioid STR - State of Maine	93.788	OSA-21-331	–	7,938
Opioid STR - State of Maine	93.788	OSA-21-332	–	20,708
Opioid STR - State of Maine	93.788	OSA-21-4007	–	195,615
Opioid STR - State of Maine	93.788	OSA-21-4007A	–	38,648
Maine State Opioid Response - State of Maine	93.788	OSA-21-4080	–	131,370
Opioid STR - State of Maine	93.788	OSA-22-332	–	3,758
Opioid STR - State of Maine	93.788	OSA-22-4080	–	4,896
Opioid STR – The Opportunity Alliance	93.788	Not identified	–	8,762
Block Grants for Community Mental Health Services - State of Maine	93.958	CBH-21-7004A	–	248,109
Block Grants for Community Mental Health Services - State of Maine	93.958	MH4-21-2020	–	620,515
Peer Run Recovery Centers - State of Maine	93.958	MH1-20-705	–	237,150
Peer Run Recovery Centers - State of Maine	93.958	MH1-21-705	–	71,360
Section 17 - State of Maine	93.958	MH1-21-7105	–	527,317
State of Maine DHHS: Substance Abuse and Mental Health Services - State of Maine	93.958	MH4-19-2019	–	7,029
State of Maine DHHS: Substance Abuse and Mental Health Services - State of Maine	93.958	MH4-20-2020	–	22,063

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued):				
Substance Abuse and Mental Health Services Administration (Continued):				
Pass-through Awards (Continued):				
ARC - OP - State of Maine	93.959	OSA-31-219	$ -	$ 141,964
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-21-329	-	20,390
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-22-4080	-	4,896
Block Grants for Prevention and Treatment of Substance Abuse – State of Maine	93.959	OSA-21-219	-	44,133
Block Grants for Prevention and Treatment of Substance Abuse – University of New England	93.959	29048B-11	-	1,275
Block Grants for Prevention and Treatment of Substance Abuse – University of New England	93.959	29048B-16	-	41,414
Block Grants for Prevention and Treatment of Substance Abuse – Maine Youth Action Network (A Program of the Opportunity Alliance)	93.959	Not identified	-	6
Block Grants for Prevention and Treatment of Substance Abuse – The Opportunity Alliance	93.959	Not identified	-	7,301
Healthy Generations - State of Maine	93.959	OSA-19-328	-	20,263
Statewide Substance Use Prevention Services - University of New England	93.959	29048A-07	-	8,963
Statewide Substance Use Prevention Services - University of New England	93.959	29048B-07	-	47,799
Statewide Substance Use Prevention Services - University of New England	93.959	29048A-11	-	1,871
Statewide Substance Use Prevention Services - University of New England	93.959	29048B-14	-	12,107
Substance Abuse Block Grant - State of Maine	93.959	OSA-21-4080	-	50,025
Total Pass-through Awards			-	2,902,743
Total Substance Abuse and Mental Health Services Administration			-	3,668,492
Administration for Children and Families Direct Awards:				
Direct Awards:				
Project BRAID: Building Resilience in Areas Impacted by Domestic Violence	93.592		-	108
Family Violence Prevention and Services	93.592		-	252,215
Total Direct Awards			-	252,323
Pass-through Awards				
Community Employment Services - State of Maine	93.667	MH4-20-009	-	97,136
Total Administration for Children and Families Direct Awards			-	349,459

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Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
Department of Health and Human Services – Other Programs (Continued):				
Administration for Community Living Direct Awards:				
Direct Awards:				
Mount Washington Valley Dementia Capable Community Program	93.470		$ –	$ 118,605
MaineHealth Alzheimer's Disease Partnership	93.763		–	114,025
Total Direct Awards			–	232,630
Pass-through Awards:				
Evidence-Based Falls Prevention Programs Financed Solely by Prevention and Public Health Funds (PPHF) – National Council on Aging (NCOA)	93.761	Not identified	–	5,000
Total Administration for Community Living Direct Awards			–	237,630
Centers for Medicare and Medicaid Services Pass-through Awards:				
Pass-through Awards:				
Maternal Opioid Misuse Model - State of Maine	93.687	OMS-21-604	–	97,353
Maternal Opioid Misuse Model - State of Maine	93.687	OMS-21-606	–	11,696
Maternal Opioid Misuse Model - State of Maine	93.687	OMS-21-606X	–	25,487
Maternal Opioid Misuse Model - State of Maine	93.687	OMS-22-604B	–	36,321
Total Centers for Medicare and Medicaid Services Pass-through Awards:			–	170,857
Total Department of Health and Human Services – Other Programs			198,368	7,485,245
United States Department of Justice – Other Programs:				
Office of Violence Against Women:				
Direct Awards:				
Coastal Forensic Nurse Examiner Program	16.589		–	154,325
Total United States Department of Justice – Other Programs			–	154,325
United States Department of Agriculture – Other Programs:				
Direct Awards:				
Distance Learning and Telemedicine Grant Agreement	10.855		–	324,620
Total United States Department of Agriculture – Other Programs			–	324,620
Social Security Administration – Other Programs:				
Direct Awards:				
WIPA – SSA – Benefits Counseling Service	96.008		–	98,640
Work Incentives Planning and Assistance Programs	96.008		–	32,251
Total Social Security Administration – Other Programs			–	130,891

MAINEHEALTH SYSTEM
(MaineHealth Services and Subsidiaries)

SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)

Year Ended September 30, 2021

Federal Grantor/Pass-Through Grantor/Program Title	Assistance Listing Number	Direct Award or Pass-Through Entity Identifying Number	Passed Through to Subrecipients	Total Federal Expenditures
United States Department of Education – Other Programs:				
Pass-through Awards:				
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20191031*1450	$ -	$ (192)
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20200819000000000575	-	882,090
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20190522000000003528	-	102,993
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.126	20201006000000001167	-	267,235
Rehabilitation Services Vocational Rehabilitation Grants to States – State of Maine	84.421	20201006000000001167	-	9,613
Total United States Department of Education – Other Programs			-	1,261,739
Total Other Programs			198,368	9,356,820
Department of Homeland Security – Disaster Grants:				
Federal Emergency Management Agency:				
Direct Awards:				
Disaster Grants – Public Assistance (Presidentially Declared Disasters) – COVID-19	97.036		-	1,690,069*
Total Department of Homeland Security – Disaster Grants			-	1,690,069
Total Expenditures and Federal Awards			$ 2,163,758	$134,419,759

* Major program

See notes to this schedule.

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MAINEHEALTH SERVICES AND SUBSIDIARIES

NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

September 30, 2021

1. **Reporting Entity**

The accompanying Supplementary Schedule of Expenditures of Federal Awards (the Schedule) presents the activity of all federal award programs of MaineHealth Services and Subsidiaries (MaineHealth) for the year beginning October 1, 2020 and ending September 30, 2021.

2. **Summary of Significant Accounting Policies**

Basis of Presentation

The accompanying Schedule has been prepared using the accrual basis of accounting and in accordance with Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). The purpose of the Schedule is to present a summary of those activities of MaineHealth for the year ending September 30, 2021, which have been supported by the U.S. Government (federal awards). For purposes of the Schedule, federal awards include all federal assistance entered into directly between the federal government and MaineHealth and federal funds awarded to MaineHealth by a primary recipient. Because the Schedule presents only a selected portion of the activities of MaineHealth, it is not intended to and does not present the consolidated financial position, results of operations, changes in net assets, and cash flows of MaineHealth and its subsidiaries.

For purposes of the Schedule, federal awards include all grants, contracts and similar agreements entered into directly between MaineHealth and agencies and departments of the federal government and all subawards to MaineHealth by nonfederal organizations pursuant to federal grants, contracts and similar agreements.

3. **Summary of Facilities and Administrative Costs**

MaineHealth recovers facilities and administrative costs (indirect costs) associated with expenditures pursuant to arrangements with the federal government. MaineHealth was awarded a provisional rate of 18.40% for the year ended September 30, 2021, based on modified total direct costs, for its research and development grant expenditures. MaineHealth has elected not to use the 10% de minimis indirect cost rate under the Uniform Guidance.

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4. **Department of Health and Human Services (HHS) Coronavirus Aid Relief and Economic Securities (CARES) Act**

The Schedule includes grant activity related to Department of Health and Human Services (HHS) Coronavirus Aid Relief and Economic Security (CARES) Act Assistance Listing Number 93.498. As required based on guidance in the 2021 OMB Compliance Supplement, the Schedule includes all Period 1 funds received between April 10, 2020 and June 30, 2020 and expended by June 30, 2021 as reported to the Health Resources and Services Administration (HRSA) Agency via the Provider Relief Fund Reporting Portal. The Schedule includes $99,222,835 of direct expenditures and lost revenue and covers the following TINs:

MaineHealth	01-0238552
Community Health and Nursing Svcs d/b/a CHANS Home Health and Hospice	01-0211546
LincolnHealth Cove's Edge	01-0382340
MaineHealth Care at Home	22-2571902
Maine Medical Partners	01-0442142
Memorial Hospital	02-0222156
Mid Coast Geriatric Services Corp	01-0496221
Mid Coast Hospital	01-0215911
NorDx	01-0511356
Quarry Hill	01-0213976
St. Joseph's Rehabilitation & Residence	01-0339489
Stephens Memorial Hospital	01-0219904
Western Maine Multi-Medical Specialists	01-0489824

5. **United States Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters)**

The Schedule includes expenditures totaling $1,690,069 being reported under the United States Department of Homeland Security Federal Emergency Management Agency (FEMA) Assistance Listing Number 97.036, Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters). Of these expenditures, $1,622,904 were incurred by MaineHealth during the year ended September 30, 2020. MaineHealth's Project Worksheet covering these expenditures was approved by FEMA during the year ended September 30, 2021 and, in accordance with the 2021 OMB Compliance Supplement, these expenditures are therefore reported on the Schedule during the year ended September 30, 2021.

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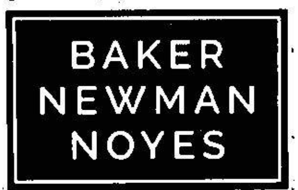

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INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

The Board of Directors
MaineHealth Services and Subsidiaries

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 MaineHealth Services and Subsidiaries (MaineHealth), which comprise the consolidated balance sheet as of September 30, 2021, and the related consolidated 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 February 4, 2022.

Internal Control Over Financial Reporting

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

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

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

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The Board of Directors
MaineHealth Services and Subsidiaries

Compliance and Other Matters

As part of obtaining reasonable assurance about whether MaineHealth'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 financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

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

Baker Newman + Noyes LLC

Portland, Maine
February 4, 2022

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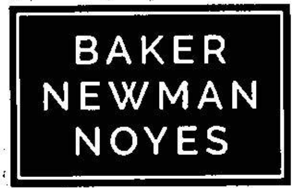

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INDEPENDENT AUDITORS' REPORT ON COMPLIANCE FOR EACH MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE REQUIRED BY THE UNIFORM GUIDANCE

The Board of Directors
MaineHealth Services and Subsidiaries

Report on Compliance for Each Major Federal Program

We have audited MaineHealth Services and Subsidiaries' (MaineHealth) compliance with the types of compliance requirements described in the *U.S. Office of Management and Budget (OMB) Compliance Supplement* that could have a direct and material effect on each of MaineHealth's major federal programs for the year ended September 30, 2021. MaineHealth's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of federal statutes, regulations, contracts, and the terms and conditions of its federal awards applicable to its federal programs.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of MaineHealth's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about MaineHealth'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 MaineHealth's compliance.

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The Board of Directors
MaineHealth Services and Subsidiaries

Opinion on Each Major Federal Program

In our opinion, MaineHealth 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, 2021.

Report on Internal Control Over Compliance

Management of MaineHealth 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 MaineHealth's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of MaineHealth's internal control over compliance.

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

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

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

Baker Newman + Noyes LLC

Portland Maine
June 6, 2022

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MAINEHEALTH SERVICES AND SUBSIDIARIES

SCHEDULE OF FINDINGS AND QUESTIONED COSTS

Year Ended September 30, 2021

I. Summary of Auditors' Results

Consolidated Financial Statements:

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	*Unmodified*
Internal control over financial reporting:	
• Material weakness(es) identified?	____ yes _X_ no
• Significant deficiency(ies) identified?	____ yes _X_ none reported
Noncompliance material to financial statements noted?	____ yes _X_ no

Federal Awards:

Internal control over major federal programs:	
• Material weakness(es) identified?	____ yes _X_ no
• Significant deficiency(ies) identified?	____ yes _X_ none reported
Type of auditors' report issued on compliance for major federal programs:	*Unmodified*
• Any audit findings disclosed that are required to be reported in accordance with Section 2 CFR 200 516(a)?	____ yes _X_ no

Identification of Major Programs:

ALN	Name of Federal Program or Cluster
93.498	Provider Relief Fund
21.019	Coronavirus Relief Fund
97.036	Disaster Grants – Public Assistance

Dollar threshold used to distinguish between type A and type B programs:	$3,000,000
Auditee qualified as low-risk auditee?	_X_ yes ____ no

II. Financial Statement Findings

Findings related to the financial statements which are required to be reported in accordance with GAS:

None noted.

III. Findings and Questioned Costs for Federal Awards

Findings required to be reported in accordance with 2 CFR 200 516(a):

None noted.

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MAINEHEALTH SERVICES AND SUBSIDIARIES

SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS

Year Ended September 30, 2021

None.

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Maine Secretary of State

2022 Annual Report
Electronic Filing Acknowledgment

For Nonprofit Corporations on file as of December 31, 2021

Charter Number: 19510013ND
DCN Number: 2220019001382
Legal Name: MAINEHEALTH

Registered Agent's Name and Address:

BETH A. KELSCH
MAINEHEALTH 110 FREE STREET
PORTLAND, ME 04101

Name and Address of Officers:

SECRETARY
BETH A. KELSCH
C/O 22 BRAMHALL STREET, PORTLAND, MAINE 04102

TREASURER
ALBERT SWALLOW, III
C/O 22 BRAMHALL STREET, PORTLAND, MAINE 04102

PRESIDENT
ANDREW MUELLER MD
C/O 22 BRAMHALL STREET, PORTLAND, MAINE 04102

VICE CHAIR
GEORGE ISAACSON, ESQ.
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

CHAIR
GREGORY DUFOUR

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C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

CHIEF EXECUTIVE OFFICER
DR. ANDREW T. MUELLER
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

Name and Address of Directors:

SANDRA MORRELL ROONEY
C/O 22 BRAMHALL STREET, PORTLAND, MAINE 04102

DOUGLAS SAWYER MD
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

SUSANNAH SWIHART
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

KATHERINE B. COSTER
22 BRAMHALL STREET, PORTLAND, MAINE 04102

JERE MICHELSON
22 BRAMHALL STREET, PORTLAND, MAINE 04102

MARIE J. MCCARTHY
22 BRAMHALL STREET, PORTLAND, MAINE 04102

THOMAS J. RYAN, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

MATTHEW CHIN
22 BRAMHALL STREET, PORTLAND, ME 04102

MORRIS FISHER
22 BRAMHALL STREET, PORTLAND, MAINE 04102

GEORGE ISAACSON
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

STUART WATSON
22 BRAMHALL STREET, PORTLAND, ME 04102

GREGORY DUFOUR
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

DAVID KUMAKI, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

L. CLINTON BOOTHBY

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C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

PETER WOOD
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

BRETT M. LOFFREDO, MD
22 BRAMHALL STREET, PORTLAND, MAINE 04102

DR. ANDREW T. MUELLER
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

PETER MANNING, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

ANN HOOPER
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

BRIAN H. NOYES
22 BRAMHALL STREET, PORTLAND, ME 04102

KATHLEEN HERLIHY, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

GEORGE (TED) HISSONG
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

NANCY HASENFUS, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

MELISSA SMITH
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

LISA BEAULE, M.D.
22 BRAMHALL STREET, PORTLAND, ME 04102

DANIEL LOISELLE,MD
22 BRAMHALL STREET, PORTLAND, ME 04102

LINDA TERRY
C/O 22 BRAMHALL STREET, PORTLAND, ME 04102

Date of Filing: May 31, 2022

Name and Capacity of Authorizing Party:

BETH KELSCH, SECRETARY

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OMB No. 0925-0001 and 0925-0002 (Rev. 03/2020 Approved Through 02/28/2023)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FIVE PAGES.**

NAME: Robert Pease Smith

eRA COMMONS USER NAME (credential, e.g., agency login): SMITHROBERT

POSITION TITLE: Director, Division of infectious Diseases, Maine Medical Center

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
Harvard College, Cambridge MA	BA	06/1971	Biology
Dartmouth Medical School, Hanover NH	MS	07/1973	Medicine
Johns Hopkins Medical School, Baltimore MD	MD	06/1975	Medicine
Internal Medicine Residency, Peter Bent Brigham Hospital, Boston MA		06/1978	Internal Medicine
Harvard School of Public Health, Boston MA	MPH	06/1979	Vector borne disease
Beth Israel Hospital/Dana Farber Cancer Center, Boston MA		06/1980	Infectious Disease

A. Personal Statement

I have extensive experience with investigations into the ecology, epidemiology and clinical assessment of tick and mosquito transmitted infectious diseases. This scope of this work includes field and bench research, as well as clinical diagnostic and outcome studies. As the Principal Investigator of the Vector-borne Disease Lab at the Maine Medical Center Research Institute, I have overseen completion of over 25 funded research projects that have focused on the emergence of vector-borne diseases in New England. Our laboratory has a 30 -year history of investigation into the range expansion of *Ixodes scapularis*, the biotic and abiotic contributors to enzootic transmission of *Borrelia burgdorferi* and other tick -borne pathogens, and interventions to prevent these diseases. We have examined the impact of deer herd density, habitat and climate on tick abundance, as well the role of different mammalian and avian hosts for *B. burgdorferi* in the maintenance of enzootic infections. As an infectious disease specialist also engaged in clinical work, I have extensive experience in the diagnosis and treatment of tick-borne diseases. As a medical educator of undergraduate and graduate students, and a director of infectious disease training programs, I am keenly interested in both the generation of clinically applicable science and also its dissemination to those who can put it to use.

1. Smith RP, Elias SP, Cavanaugh CE, Lubelczyk CB, Lacombe EH, Brancato J, Doyle H, Rand PW, Ebel GD, Krause PJ. Seroprevalence of *Borrelia burgdorferi*, *B. miyamotoi*, and Powassan virus in residents bitten by *Ixodes* ticks, Maine USA. Emerg Infect Dis 2019; Apr.25(4):804-807 PubMed Central PMCID:PMC6433028.
2. Smith RP, McCarthy C, Elias SP, Increasing actual and perceived burden of tick-borne disease in Maine. Journal of Maine Medical Center.2019 July 01; 1(1):13. Available from: https://knowledgeconnection.mainehealth.org/jmmc/vol1/iss1/13
3. Smith RP, Elias SP, Borelli T, Missaghi B, York BJ, Kessler RA, Lubelczyk CB, Lacombe EH, Hayes CM, Coulter MS, Rand PW. Human babesiosis, Maine USA, 1995-2011. Emerg Infect Dis 2014; 20: 1723-1726. PMID 25272145.

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4. Smith RP, Schoen RT, Rahn DW, Sikand VK, Nowakowski J, Parenti D, Holman MS, Persing DH, Steere AC. Clinical characteristics and treatment outcome of early Lyme disease in patients with microbiologically confirmed erythema migrans. Ann Intern Medicine 2002 Mar 19; 136(6): 421-8. PMID: 11900494

B. Positions, Scientific Appointments and Honors

2015 - present, Professor of Medicine, Tufts University School of Medicine
2014 – present, Director, Division of Infectious Diseases, Maine Medical Center
2005 - 2015, Clinical Professor of Medicine, Tufts University School of Medicine
1995 - 2005, Clinical Professor of Medicine, University of Vermont Medical School
1991 - present, PI (Director), Vector-borne Disease Lab, Maine Medical Center Research Institute
1987 - present, Physician, Maine Medical Center, Portland Maine
1986 - 1987, Associate Professor of Medicine, Dartmouth Medical School
1980 - 1987, Physician, Dartmouth –Hitchcock Medical Center, Hanover NH

Honors

2014, Mentor of the Year Award, Maine Medical Center Research Institute
2011, John Snow Award, Vector –borne Disease Laboratory, Maine CDC
2005, Clinical Research Award, Maine Medical Center
1997, Master Teaching Award, Maine Medical Center
1996, Appointed to Fellowship, Infectious Disease Society of America
1992, Keynote Speaker and Award, American College of Physicians, Maine Chapter
1988, State Epidemiology Award, Maine CDC

C. Contributions to Science

1. Epidemiology and clinical recognition of Lyme disease and other tick-borne diseases
My clinical interest in the emergence of tick-borne diseases includes 2 decades of investigations in tandem with public health and clinical colleagues on the appearance of newly recognized tick-borne infections (i.e., Lyme disease, anaplasmosis, babesiosis, Powassan virus and *B. miyamotoi* infection) in northern New England. As a consequence of this involvement, I have contributed to our understanding of the spectrum of presentations of early Lyme disease, the clinical management of Lyme arthritis and Lyme carditis, and have investigated novel approaches to diagnosis of neuroborreliosis. Additional contributions to the clinical literature on tick-borne infections include epidemiologic studies and reviews of babesiosis, Powassan virus infection, and anaplasmosis In addition, my work here includes dissemination of clinical scientific advances on these diseases through publications, national and regional symposia, and formal training programs for medical residents and fellows.
    a. Shen RV, McCarthy C, Smith RP. Lyme carditis in hospitalized children and adults, a case series. Open Forum Infect Dis 2021; Mar 23; 8(7):ofab 140. Doi: 10.1093/ofid/ofab140. eCollection 2021 Jul. PMCID: PMC8266570.
    b. Smith RP, Hunfeld K-P, Krause PK. Management strategies for human babesiosis. Expert Rev Anti-infect Ther. 2020 Jul; 18(7): 625-636. PMID: 32268823.
    c. Daikh BE, Emerson FE, Smith RP, Lucas FL, McCarthy CA. Lyme arthritis: a comparison of presentation, synovial fluid analysis, and treatment course in children and adults. Arthritis Care Res 2013; 65: 1986-1990. PMID: 23925915.
    d. Angel T, Jacobs JM, Smith RP, Pasternack MS, Elias SE, Gritsenko MA, Shukla A, Gilmore EC, McCarthy CM, Camp DG, Smith RD, Warren HS. Cerebrospinal fluid proteome of patients with acute Lyme disease. J Proteome Res 2012; 11(10): 4814-22; PMID: 22900834.

2. Ecology of emerging vector borne diseases
My peer reviewed published contributions include demonstration of dispersal of *Ixodes scapularis* ticks by migratory birds, delineation of reservoir hosts for *Borrelia burgdorferi*, studies parsing the role of abiotic and biotic factors in establishment of vector ticks, molecular epidemiologic studies of emergent Lyme disease, babesiosis,and Powassan and Eastern equine encephalitis virus.

a. Elias SP, Gardner AM, Maasch KA, Birkel SD, Anderson NT, Rand PW, Lubelczyk CB, Smith RP. A generalized additive model correlating blacklegged ticks with white-tailed deer density, temperature, and humidity in Maine, USA, 1990-2013. J Med Entomol 2021 Jan 12 ; 58(1): 125-138. PubMed PMID: 32901284.
b. Elias SP, Maasch KA, Anderson NT, Rand PW, Lacombe EH, Robich RM, Lubelczyk CB, Smith RP . Decoupling of blacklegged tick abundance and Lyme disease incidence in southern Maine. J Med Entomol.2020 May 4; 57(3): 755-766. PubMed PMID 31808817.
c. Smith RP, Rand PW, Lacombe EH Telford ST, Rich SM, Piesman J, Spielman A.. Norway rats as reservoir hosts for Lyme disease spirochetes on Monhegan Island, Maine. J Infect Dis 1993; 168: 687-691.
d. Smith RP, Rand PW, Lacombe EH Morris SR, Holmes DW, Caporale DA.. Role of bird migration in the long -distance dispersal of *Ixodes dammini*, the vector of Lyme disease. J Infect Dis 1996; 174: 221-24

3. Public health interventions for tick-borne diseases
In concert with our laboratory's work on the ecology of tick-borne infections, we have investigated environmental interventions (i.e, acaricide trials, deer control) and participated as a study site for a Lyme disease vaccine trial.

a. Elias SP, Stone BB, Rand PW, Lubelczyj CB, Smith RP. History of deer reduction for tick control on
Maine's offshore islands. Maine Policy Review. 2021 Mar 01;30 (1). Available from: https://digital commons.library.umaine.edu/mpr/vol30/iss1/1/
b. Elias SP, Lubelczyk CB, Rand PW, Staples JK, St Amand TW, Stubbs CS, Lacombe EH, Smith LB, Smith RP. Effect of a botanical acaricide on *Ixodes scapularis* (Acari: Ixodidae) and nontarget arthropods. J Med Entomol. 2013 Jan; 50(1): 126-136. PubMed PMID: 23427661.
c. Rand PW, Lacombe EH, Elias SP, Lubelczyk CB, St Amand T, Smith RP. Trial of a minimal-risk botanical compound to control the vector tick of Lyme disease. J Med Entomol 2010 Jul: 47(4): 695-698. PubMed PMID: 20695287.
d. Rand PW, Lubelczyk CB, Holman MS, Lacombe EH, Smith RP. Abundance of *Ixodes scapularis* following the complete removal of deer from an isolated offshore island endemic for Lyme disease.
J Med Entomol. 2004; 41:179-184.

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OMB No. 0925-0001 and 0925-0002 (Rev. 12/2020 Approved Through 02/28/2023)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FIVE PAGES.**

NAME: Charles B. Lubelczyk

eRA COMMONS USER NAME (credential, e.g., agency login): CLUBELCZYK

POSITION TITLE: Vector Ecologist, Maine Medical Center, Portland, ME

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	Completion Date MM/YYYY	FIELD OF STUDY
University of New Hampshire, Durham NH	BS	05/1997	Wildlife Management
University of New England, Biddeford ME	MPH	06/2018	Public Health

A. Personal Statement

The study of vector-borne diseases is, at its core, multidisciplinary. Entomology, clinical medicine, public health and wildlife science are just a few of the threads that contribute to its complexity. For me, the idea of a large, cohesive merger of many fields investigating this problem made sense. That there was a definitive link between the rise of tick-borne disease and biotic factors, such as a rise in deer populations in the northeastern US, I firmly believe. But at the same time, we have climate impacts, land use practices such as suburbanization (and exurbanization), and a reluctance or resistance to classic approaches to pest management. I also firmly believe that successful management of tick-borne disease on the landscape can only be achieved with a cross-disciplinary approach, enjoining clinicians, natural resource managers, . veterinarians, and others to engage and interact on surveillance, data-sharing, and outreach to the general public.

B. Positions, Scientific Appointments and Honors

Positions, Scientific Appointments

2016	Adjunct Instructor, University of Southern Maine, Dept. of Environmental Science and Policy, Gorham, ME
2000, 2006	Environmental Consultant, Wells National Estuarine Research Reserve (WNERR), Wells, ME
1998- Present	Vector Ecologist, Maine Medical Center Research Institute, Vector-borne Disease Laboratory, Scarborough, ME
1994-1997	Field Technician, Maine Medical Center Research Institute, Vector-borne Disease Laboratory, Scarborough, ME
1993	Laboratory Technician, Normandeau Associates, Bedford, NH

Other Experience and Professional Memberships

2018-Present	Entomological Society of America
2011- Present	Northeast Mosquito Control Association
2008-Present	American Mosquito Control Association
2002-Present	Wildlife Disease Association
2001- Present	Vector-borne Work Group, State of Maine

C. Contributions to Science

1. Role of invasive plants as optimal habitat for ticks. Landscape change is an important ecologic process being seen in the northeastern US. Many disturbed ecological communities are infested with colonizing invasive/exotic vegetation, which has come to dominate the forest understory. The role that exotic vegetation

may play as habitat for ticks is particularly important for natural resource managers, who are tasked with removing the plants from areas. A public health concern regarding plants such as Japanese barberry adds incentive for their eradication.

a. Lubelczyk C, S. P. Elias, P.W. Rand, M.S. Holman, E.H. Lacombe, and R.P. Smith, Jr.: Habitat associations of Ixodes scapularis (Acari:Ixodidae) in Maine. Environ. Entomol. 33(4): 900-906, 2004.
b. Elias SP, **Lubelczyk CB**, Rand PW, Lacombe EH, Holman MS, Smith RP Jr. Deer browse resistant exotic-invasive understory: an indicator of elevated human risk of exposure to *Ixodes scapularis* (Acari: Ixodidae) in southern coastal Maine woodlands. J Med Entomol. 2006 Nov;43(6):1142-52. doi: 10.1603/0022-2585(2006)43[1142:dbreua]2.0.co;2. PMID: 17162946.

2. Importance of collaborative surveillance programs for emerging disease issues. The northeastern US, and in particular, northern New England, has seen the emergence of several vector-borne diseases in the last decade, including Powassan encephalitis virus and eastern equine encephalitis virus. We have been fortunate to be able to create and maintain a collaborative surveillance program for emerging vector-borne diseases, primarily through wildlife surveys. Started in 2009, this program has expanded from Maine and is being used in other New England states such as New Hampshire and Vermont.

a. Hinten SR, Beckett GA, Gensheimer KF, Pritchard E, Courtney TM, Sears SD, Woytowicz JM, Preston DG, Smith RP Jr, Rand PW, Lacombe EH, Holman MS, **Lubelczyk CB**, Kelso PT, Beelen AP, Stobierski MG, Sotir MJ, Wong S, Ebel G, Kosoy O, Piesman J, Campbell GL, Marfin AA. Increased recognition of Powassan encephalitis in the United States, 1999-2005. Vector Borne Zoonotic Dis. 2008 Dec;8(6):733-40. doi: 10.1089/vbz.2008.0022. PMID: 18959500.
b. **Lubelczyk C**, Mutebi JP, Robinson S, Elias SP, Smith LB, Juris SA, Foss K, Lichtenwalner A, Shively KJ, Hoenig DE, Webber L, Sears S, Smith RP Jr. An epizootic of eastern equine encephalitis virus, Maine, USA in 2009: outbreak description and entomological studies. Am J Trop Med Hyg. 2013 Jan;88(1):95-102. doi: 10.4269/ajtmh.2012.11-0358. Epub 2012 Dec 3. PMID: 23208877; PMCID: PMC3541751.
c. Nofchissey RA, Deardorff ER, Blevins TM, Anishchenko M, Bosco-Lauth A, Berl E, **Lubelczyk C**, Mutebi JP, Brault AC, Ebel GD, Magnarelli LA. Seroprevalence of Powassan virus in New England deer, 1979-2010. Am J Trop Med Hyg. 2013 Jun;88(6):1159-62. doi: 10.4269/ajtmh.12-0586. Epub 2013 Apr 8. PMID: 23568288; PMCID: PMC3752817.
d. Mutebi JP, Mathewson AA, Elias SP, Robinson S, Graham AC, Casey P, **Lubelczyk CB**. Use of Cervid Serosurveys to Monitor Eastern Equine Encephalitis Virus Activity in Northern New England, United States, 2009-2017. J Med Entomol. 2021 Nov 4:tjab133. doi: 10.1093/jme/tjab133. Epub ahead of print. PMID: 34734629.

3. Role of overwintering conditions in survival of tick species in northern New England. Because of different climatic and habitat variables, it is suspected that areas of northern New England might contain range limits for tick expansion, especially in species that have been imported or introduced from southern regions of the United States. In particular, snow depth and leaf litter composition are seen as key features in overwintering survival of ticks.

a. Rand PW, Holman MS, **Lubelczyk C**, Lacombe EH, DeGaetano AT, Smith RP Jr. Thermal accumulation and the early development of *Ixodes scapularis*. J Vector Ecol. 2004 Jun;29(1):164-76. PMID: 15266754.
b. Linske MA, Stafford KC 3rd, Williams SC, **Lubelczyk CB**, Welch M, Henderson EF. Impacts of Deciduous Leaf Litter and Snow Presence on Nymphal *Ixodes scapularis* (Acari: Ixodidae) Overwintering Survival in Coastal New England, USA. Insects. 2019 Jul 30;10(8):227. doi: 10.3390/insects10080227. PMID: 31366124; PMCID: PMC6723576.
c. Linske MA, Williams SC, Stafford KC 3rd, **Lubelczyk CB**, Henderson EF, Welch M, Teel PD. Determining Effects of Winter Weather Conditions on Adult *Amblyomma americanum* (Acari: Ixodidae) Survival in Connecticut and Maine, USA. Insects. 2019 Dec 21;11(1):13. doi: 10.3390/insects11010013. PMID: 31877783; PMCID: PMC7023149.
d. Volk MR, **Lubelczyk CB**, Johnston JC, Levesque DL, Gardner AM. Microclimate conditions alter *Ixodes scapularis* (Acari: Ixodidae) overwinter survival across climate gradients in Maine, United States. Ticks Tick Borne Dis. 2022 Jan;13(1):101872. doi: 10.1016/j.ttbdis.2021.101872. Epub 2021 Nov 19. PMID: 34826798.

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BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. DO NOT EXCEED FIVE PAGES.

NAME: Elias, Susan

eRA COMMONS USER NAME (credential, e.g., agency login): eliassusan

POSITION TITLE: Staff Scientist

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)*

INSTITUTION AND LOCATION	DEGREE (if applicable)	END DATE MM/YYYY	FIELD OF STUDY
University of Maine, Orono, ME	BS	05/1984	Wildlife Management
Virginia Polytechnic Institute & State University, Blacksburg, Virginia	MS	07/1994	Wildlife Science
University of Maine, Orono, ME	PHD	05/2019	Earth and Climate Sciences

A. Personal Statement

Since 1988 the Maine Medical Center Research Institute's Vector-borne Disease Laboratory has conducted translational research that unites vector ecology, clinical studies, and public health. For over two decades I have been a vector ecologist with our team, designing, conducting, and publishing results of studies related to vector ecology and vector-borne disease. I have served as a research coordinator in human studies that assessed exposure to vector-borne pathogens, KAB (knowledge, attitude, and behavior), and antibody response during early Lyme disease (NIH SBIR Phase I). As senior staff at my laboratory, I have the experience to run research programs and provide strong support to other staff, my PI, and external collaborators. I am particularly interested in integration and statistical analysis of data related to vector-borne disease in vector, animal, and human populations. Given a rural population at high risk of contracting vector-borne disease in Maine, as well as our established human subjects research protocols and sites, we are well-positioned to provide a robust sample of patients diagnosed with tick-borne diseases, including early Lyme disease.

1. Elias SP, Maasch KA, Anderson NT, Rand PW, Lacombe EH, Robich RM, Lubelczyk CB, Smith RP. Decoupling of Blacklegged Tick Abundance and Lyme Disease Incidence in Southern Maine, USA. J Med Entomol. 2020 May 4;57(3):755-765. PubMed PMID: 31808817.
2. Elias SP, Bonthius J, Robinson S, Robich RM, Lubelczyk CB, Smith RP Jr. Surge in Anaplasmosis Cases in Maine, USA, 2013-2017. Emerg Infect Dis. 2020 Feb;26(2):327-331. PubMed Central PMCID: PMC6986843.
3. Smith RP, McCarthy C, Elias SP. Increasing actual and perceived burden of tick-borne disease in Maine. Journal of Maine Medical Center. 2019 July 01; 1(1):13. Available from: https://knowledgeconnection.mainehealth.org/jmmc/vol1/iss1/13
4. Ogden NH, Bouchard C, Badcock J, Drebot MA, Elias SP, Hatchette TF, Koffi JK, Leighton PA, Lindsay LR, Lubelczyk CB, Peregrine AS, Smith RP, Webster D. What is the real number of Lyme disease cases in Canada?. BMC Public Health. 2019 Jun 28;19(1):849. PubMed Central PMCID: PMC6599318.

B. Positions, Scientific Appointments and Honors

Positions and Scientific Appointments

2022 – present External Research Associate Scientist, University of Maine

2019 – present Scientific and Technical Subcommittee Member, Maine Climate Council, Augusta, ME

2000 – present Staff Scientist, Maine Medical Center Research Institute Vector-borne Disease Laboratory, Scarborough, ME

2000 - present	Member, Vector-borne Disease Work Group, Augusta, ME
1998 – 2007	Research Associate, University of Maine Dept. of Wildlife Ecology, Orono, ME
1991 - 1994	Graduate Research Assistant/Research Associate, Virginia Tech Dept. of Fisheries and Wildlife Sciences, Blacksburg, VA
1981 - 1985	Research Assistant, University of Maine Dept. of Geological Sciences, Orono, ME

Honors

2018	Susan J. Hunter Presidential Research Impact Award, University of Maine
2017 - 2019	University of Maine Chase Distinguished Research Assistantship, University of Maine
2015 - 2017	National Science Foundation Integrative Graduate Education and Research Traineeship, National Science Foundation

C. Contributions to Science

1. Tick-borne disease discovery in humans is improving as clinicians and patients become more aware of ticks, and as tick-borne disease testing becomes more sophisticated. Our work has shown that while these are positive developments, increased disease discovery can lead to a disconnect between entomological risk and burden of disease. Increased disease discovery can also influence the media and thereby public perception of the burden of tick-borne disease. These findings should encourage people using tick-borne disease incidence data to carefully examine the way the data are generated before making conclusions about trends or correlations. My role in this work has been to procure, examine, and interpret disease incidence and entomological data, and publish and present these findings.

   a. Elias SP, Maasch KA, Anderson NT, Rand PW, Lacombe EH, Robich RM, Lubelczyk CB, Smith RP. Decoupling of Blacklegged Tick Abundance and Lyme Disease Incidence in Southern Maine, USA. J Med Entomol. 2020 May 4;57(3):755-765. PubMed PMID: 31808817.

   b. Elias SP, Bonthius J, Robinson S, Robich RM, Lubelczyk CB, Smith RP Jr. Surge in Anaplasmosis Cases in Maine, USA, 2013-2017. Emerg Infect Dis. 2020 Feb;26(2):327-331. PubMed Central PMCID: PMC6986843.

   c. Smith RP, McCarthy C, Elias SP. Increasing actual and perceived burden of tick-borne disease in Maine. Journal of Maine Medical Center. 2019 July 01; 1(1):13. Available from: https://knowledgeconnection.mainehealth.org/jmmc/vol1/iss1/13

   d. Ogden NH, Bouchard C, Badcock J, Drebot MA, Elias SP, Hatchette TF, Koffi JK, Leighton PA, Lindsay LR, Lubelczyk CB, Peregrine AS, Smith RP, Webster D. What is the real number of Lyme disease cases in Canada?. BMC Public Health. 2019 Jun 28;19(1):849. PubMed Central PMCID: PMC6599318.

2. Our lab has conducted long-term surveillance of vector ticks and mosquitos and their hosts in Maine for over 30 years, and human and wildlife serosurveys over the past decade. These programs have shown that human and veterinary populations are at risk for tick- and mosquito-borne disease in Maine and northern New England. Maine is a rural state with high Lyme disease incidence, and increasing incidence of anaplasmosis and babesiosis. Given a rural population at high risk of contracting vector-borne disease, as well as our established human subjects research protocols and sites, we are well-positioned to provide a robust sample of patients diagnosed with tick-borne diseases, including early Lyme disease. My role in this work has been in study design, grant preparation, IRB submissions, project supervision and research coordination, data collection and management, statistical analysis, manuscript preparation and publication, and public presentation of results.

   a. Robich RM, Cosenza DS, Elias SP, Henderson EF, Lubelczyk CB, Welch M, Smith RP. Prevalence and Genetic Characterization of Deer Tick Virus (Powassan Virus, Lineage II) in *Ixodes scapularis* Ticks Collected in Maine. Am J Trop Med Hyg. 2019 Aug;101(2):467-471. PubMed Central PMCID: PMC6685567.

   b. Smith RP Jr, Elias SP, Cavanaugh CE, Lubelczyk CB, Lacombe EH, Brancato J, Doyle H, Rand PW, Ebel GD, Krause PJ. Seroprevalence of *Borrelia burgdorferi*, *B. miyamotoi*, and Powassan Virus in

Residents Bitten by Ixodes Ticks, Maine, USA. Emerg Infect Dis. 2019 Apr;25(4):804-807. PubMed Central PMCID: PMC6433028.

c. Elias SP, Keenan P, Kenney JL, Morris SR, Covino KM, Robinson S, Foss KA, Rand PW, Lubelczyk C, Lacombe EH, Mutebi JP, Evers D, Smith RP Jr. Seasonal Patterns in Eastern Equine Encephalitis Virus Antibody in Songbirds in Southern Maine. Vector Borne Zoonotic Dis. 2017 May;17(5):325-330. PubMed PMID: 28287934.
d. Rand PW, Lacombe EH, Dearborn R, Cahill B, Elias S, Lubelczyk CB, Beckett GA, Smith RP Jr. Passive surveillance in Maine, an area emergent for tick-borne diseases. J Med Entomol. 2007 Nov;44(6):1118-29. PubMed PMID: 18047214.

3. Over a 30-year period our lab has provided robust evidence that white-tailed deer play a key role in maintaining blacklegged ticks (*Ixodes scapularis*). Building on prior work done by our lab, my most recent scientific contributions show that I. scapularis abundance in northern Maine is likely to increase due to climate change, which is manifested by warming winters, increasing relative humidity, and increasing degree-day accumulation. My work also has illustrated history of and attitudes towards deer herd reduction in communities attempting to lower the risk of tick bite and tick-borne disease. My role in this work has been in study design, grant preparation, IRB submissions, project supervision and research coordination, data collection and management, statistical analysis, manuscript preparation and publication, and public presentation of results.

   a. Elias SP, Rand PW, Rickard LN, Stone BB, Maasch KA, Lubelczyk CB, Smith RP Jr. Support for deer herd reduction on offshore Islands of Maine, U.S.A. Ticks Tick Borne Dis. 2021 Mar;12(2):101634. PubMed PMID: 33370715.
   b. Elias SP, Stone BB, Rand PW, Lubelczyk CB, Smith RP. History of deer herd reduction for tick control on Maine's offshore islands. Maine Policy Review. 2021 March 01; 30(1):1. Available from: https://digitalcommons.library.umaine.edu/mpr/vol30/iss1/1/
   c. Elias SP, Gardner AM, Maasch KA, Birkel SD, Anderson NT, Rand PW, Lubelczyk CB, Smith RP. A Generalized Additive Model Correlating Blacklegged Ticks With White-Tailed Deer Density, Temperature, and Humidity in Maine, USA, 1990-2013. J Med Entomol. 2021 Jan 12;58(1):125-138. PubMed PMID: 32901284.
   d. Elias SP, Smith RP Jr, Morris SR, Rand PW, Lubelczyk C, Lacombe EH. Density of *Ixodes scapularis* ticks on Monhegan Island after complete deer removal: a question of avian importation?. J Vector Ecol. 2011 Jun;36(1):11-23. PubMed PMID: 21635637.

4. Eastern Equine Encephalitis virus (EEEv) causes severe illness and death in humans. Historically there has been less EEEv activity in Maine than in more southernly Northeastern US states and even New Hampshire and Vermont, which could be related to factors including historically colder climate. Our research has shown serological evidence from deer and moose that EEEv has a statewide distribution, yet human and veterinary EEEv cases and positive mosquitoes have focal distributions within the warmer southern half of the state. I have shown that the frequency of antibody to EEEv juvenile songbirds reflects seasonal fluctuations in EEEv amplification in vector mosquitoes. Given these geospatial and temporal studies, long-term mosquito surveillance data, and partnerships with collaborators with similar datasets, we are poised to better understand what biotic and climatological factors allow focal amplification of EEEv across the latitudinal extent of the US Northeast in an era of rapid climate change. My role in this work has been in study design, grant preparation, project supervision, data collection and management, statistical analysis, manuscript preparation and publication, and public presentation of results.

   a. Mutebi JP, Mathewson AA, Elias SP, Robinson S, Graham AC, Casey P, Lubelczyk CB. Use of Cervid Serosurveys to Monitor Eastern Equine Encephalitis Virus Activity in Northern New England, United States, 2009-2017. J Med Entomol. 2021 Nov 4; PubMed PMID: 34734629.
   b. Kenney JL, Henderson E, Mutebi JP, Saxton-Shaw K, Bosco-Lauth A, Elias SP, Robinson S, Smith RP, Lubelczyk C. Eastern Equine Encephalitis Virus Seroprevalence in Maine Cervids, 2012-2017. Am J Trop Med Hyg. 2020 Dec;103(6):2438-2441. PubMed Central PMCID: PMC7695117.
   c. Elias SP, Keenan P, Kenney JL, Morris SR, Covino KM, Robinson S, Foss KA, Rand PW, Lubelczyk C, Lacombe EH, Mutebi JP, Evers D, Smith RP Jr. Seasonal Patterns in Eastern Equine Encephalitis

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Virus Antibody in Songbirds in Southern Maine. Vector Borne Zoonotic Dis. 2017 May;17(5):325-330. PubMed PMID: 28287934.

d. Lubelczyk C, Mutebi JP, Robinson S, Elias SP, Smith LB, Juris SA, Foss K, Lichtenwalner A, Shively KJ, Hoenig DE, Webber L, Sears S, Smith RP Jr. An epizootic of eastern equine encephalitis virus, Maine, USA in 2009: outbreak description and entomological studies. Am J Trop Med Hyg. 2013 Jan;88(1):95-102. PubMed Central PMCID: PMC3541751.

5. Our laboratory was the first to recognize nonnative, invasive Japanese barberry as optimal tick habitat. This has spurred more research into tick-associated invasive plant ecology and control in other parts of the US Northeast. It also has raised awareness among lay audiences of how problematic Japanese barberry is. Our laboratory also has contributed to the body of work on efficacy of non-synthetic acaricides. My role in this work has been in study design, grant preparation, project supervision, data collection and management, statistical analysis, manuscript preparation and publication, and public presentation of results.

a. Elias SP, Lubelczyk CB, Rand PW, Staples JK, St Amand TW, Stubbs CS, Lacombe EH, Smith LB, Smith RP Jr. Effect of a botanical acaricide on *Ixodes scapul*aris (Acari: Ixodidae) and nontarget arthropods. J Med Entomol. 2013 Jan;50(1):126-36. PubMed PMID: 23427661.

b. Rand PW, Lacombe EH, Elias SP, Lubelczyk CB, St Amand T, Smith RP Jr. Trial of a minimal-risk botanical compound to control the vector tick of Lyme disease. J Med Entomol. 2010 Jul;47(4):695-8. PubMed PMID: 20695287.

c. Elias SP, Lubelczyk CB, Rand PW, Lacombe EH, Holman MS, Smith RP Jr. Deer browse resistant exotic-invasive understory: an indicator of elevated human risk of exposure to *Ixodes scapularis* (Acari: Ixodidae) in southern coastal Maine woodlands. J Med Entomol. 2006 Nov;43(6):1142-52. PubMed PMID: 17162946.

d. Lubelczyk CB, Elias SP, Rand PW, Holman MS, Lacombe EH, Rand PW. Habitat associations of *Ixodes scapularis* (Acari: Ixodidae) in Maine. Environmental entomology. 2004 August 01; 33(4):900. Available from: https://doi.org/10.1603/0046-225X-33.4.900

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CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Salary Amount Paid from this Contract	Fringe Amount Paid from this Contract	Salary and Fringe Paid from this Contract
Robert Smith	Clinician/PI	$203,700	.1923	$392	$120	$512
Charles Lubelczyk	Project Manager	$96,658	.9615	$929	$285	$1,214
Susan Elias	Biostatistician	$93,381	.5769	$539	$165	$704