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Lori A. Shibinette
Commissioner

Katja S. Fox
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
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January 21, 2021

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 for Behavioral Health, to enter into a **Retroactive, Sole Source** amendment to an existing contract with Mary Hitchcock Memorial Hospital, (VC#177160), Lebanon, NH to provide integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder, by increasing the price limitation by $1,200,000 from $4,255,413 to $5,455,413 and by extending the completion date from September 30, 2020 to September 29, 2021, effective retroactive to September 30, 2020 upon Governor and Council approval. 100% Federal Funds.

The original contract was approved by Governor and Council on January 24, 2018, item #8 and most recently amended with Governor and Council approval on October 2, 2019, item #16A.

Funds are available in the following account for State Fiscal Year 2021 and are anticipated to be available in State Fiscal Year 2022, 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.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2018	102-500731	Contracts for Program Services	92052559	$862,630	$0	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813	$0	$1,892,813
2020	102-500731	Contracts for Program Services	92052559	$600,000	$0	$600,000
			Subtotal	***$3,355,443***	***$0***	***$3,355,443***

05-95-92-920510-70400000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, STATE OPIOID RESPONSE GRANT

State Fiscal Year	Class / Account	Class Title	Job Number	Current Budget	Increased (Decreased) Amount	Revised Budget
2020	102-500731	Contracts for Program Services	92057040	$ 603,472	$0	$ 603,472
2021	102-500731	Contracts for Program Services	92057046	$296,498	$900,000	$1,196,498
2022	102-500731	Contracts for Program Services	92057046	$0	$300,000	$300,000
			Subtotal	***$899,970***	***$1,200,000***	***$2,099,970***
			Total	**$4,255,413**	**$1,200,000**	**$5,455,413**

EXPLANATION

This request is **Retroactive** because there cannot be a lapse in client services and the Department did not receive the federal award letter for funding in time to submit this request prior to the current contract expiring. Additionally, funds anticipated to be available in Fiscal Year 2020 were not yet appropriated in the operating budget. This request is **Sole Source** because the completion date is being extended beyond the remaining renewal option.

The purpose of this request is to allow the Contractor to continue serving the target population and geographic areas without interruption at seven (7) sites. The Contractor will continue providing integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. MAT services will be integrated with prenatal and postpartum care, and provided with parenting support and education at seven (7) sites across New Hampshire, including sites in the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

Approximately 1,000 individuals will be served from September 30, 2020 through September 29, 2021.

The State continues to need population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers offer integration of services, approaches to meet individual client needs, and the means to maximize State and Federal dollars to meet the demand for these specific services. The services provided by the Contractor will be comprehensive and focus not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

The Department will monitor contracted services using the following performance measures:

- Fifty percent (50%) of women referred to the program, who consent to treatment and qualify based on clinical evaluation, will enter opioid use disorder (OUD) treatment as reported by the Contractor.
- Seventy-five percent (75%) of women identified by American Society of Addiction Medicine (ASAM) criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.
- Five percent (5%) decline in neonatal abstinence syndrome (NAS) rates of infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed, as reported by the Contractor.
- Five percent (5%) decrease in positive urine drug screens for illicit substances for pregnant women served in this program as reported by the Contractor.
- Five percent (5%) decrease in reports to Division for Children, Youth, and Family (DCYF) of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as reported by the Contractor and through the use of collected hospital and DCYF data.

As referenced in Exhibit C-1, Revisions to General Provisions, Section 3, Extension, of the original contract, the parties have the option to extend the agreement for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and Governor and Council approval. The Department is exercising its option to renew services for the remaining nine (9) months available as well as extending the contract an additional three (3) months.

Should the Governor and Council not authorize this request, pregnant women and parents in recovery may not receive the supports necessary to maintain sobriety.

Area served: Statewide

Source of Funds: CFDA #93.788, FAIN TI083326.

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

Respectfully submitted,

Lori A. Shibinette
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
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Denis Goulet
Commissioner

December 18, 2020

Lori A. Shibinette, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Shibinette:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a sole source and retroactive contract amendment with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047B.

> This is a request to amend a current contract for Mary Hitchcock Memorial Hospital to continue providing integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. Mary Hitchcock Memorial Hospital will continue serving the target population and geographic areas without interruption at seven (7) stand up sites.
>
> The funding amount for this amendment is $1,200,000 increasing the current contract from $4,255,413 to $5,455,413, retroactive to October 1, 2020 and by extending the completion date from September 30, 2020 to September 29, 2021, effective upon Governor and Executive Council approval.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/ik
DoIT #2018-047B
cc: Michael Williams, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #2 to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women Contract

This 2nd Amendment to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women contract (hereinafter referred to as "Amendment #2") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a domestic nonprofit corporation with a place of business at One Medical Drive, Lebanon, NH 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 24, 2018, (Item #8), as amended on October 2, 2019, (Item #16A), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended) and in consideration of certain sums specified; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, Extension, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

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

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

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 29, 2021.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $5,455,413.

3. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.1. to read:

   2.1 The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders. The Contractor shall:

   2.1.1 Ensure services are integrated with prenatal and postpartum care.

   2.1.2. Provide parenting support and education for parents at five (5) sites across the State of New Hampshire.

   2.1.3. Ensure one (1) of the five (5) sites in 2.1.2. is located in Coos County.

   2.1.4. Provide copies of the executed agreements with the sites described in Subsection 2.1, to the Department within five (5) business days of fully executing the documents.

   2.1.5. Obtain approval from the Department for each executed agreement and subsequent renewal.

4. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.3. to read:

   2.3. The Contractor shall ensure delivery of the required services at the four (4) other sites

where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services.

5. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.5. to read:

   2.5. The Contractor shall provide services at all five (5) sites including, but not limited to:

   2.5.1 Peer recovery coaches.

   2.5.2. Resource/Employment specialists.

   2.5.3. Case management/Care coordination.

   2.5.4. Parenting education groups.

   2.5.5. Health education.

   2.5.6. Social supports including, but not limited to access and/or referrals to food, housing, child care, and transportation services.

6. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Paragraph 2.8.6. to read:

   2.8.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction, when possible given pandemic restrictions.

7. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.20. to read:

   2.20. The Contractor shall ensure that D-H Lebanon Addiction Treatment Program protocol for PDMP monitoring includes, but is not limited to, reviewing the PDMP at a patient's first visit and when clinically indicated.

8. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Paragraph 2.23.1. to read:

   2.23.1. Using their Patient Advisory Board, which meets biannually and is composed of participants in long-term recovery.

9. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.24. to read:

   2.24. The Contractor provide assistance with accessing child care services that includes, but is not limited to on-site well-child care at the D-H Lebanon Moms in Recovery Program, when possible during pandemic restrictions, to ensure lack of child care is not a barrier to accessing treatment.

10. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Paragraph 2.26.2. to read:

    2.26.2. Collecting data on participant demographics utilizing a REDCap database designed for this purpose, which allows de-identified, participant-level data to be entered remotely by all sites. The Contractor shall ensure:

    2.26.2.1. Data is entered for each participant from the time of entry into the program for up to a minimum of three (3) months postpartum.

    2.26.2.2. Sites have the option to follow participants longer, if consistent with practice operations. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of

pregnancy, at delivery, and at three (3) months postpartum.

2.26.2.3. Data is available for utilization in quality improvement initiatives and program evaluation, as well as development of targeted services at all sites

11. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Paragraph 2.26.5. to read:

2.26.5. Employing a research assistant to assist with data entry and quality.

12. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.28. to read:

2.28. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects that include, but are not limited to:

2.28.1. Quarterly web-based discussions and trainings.

2.28.2. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

13. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.29. to read:

2.29. The Contractor shall participate in the development of a Safe Plan of Care for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder. The Contractor shall ensure participation with:

2.29.1. Birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF);, which includes, but is not limited to:

2.29.2. Other community agency supports, which may include but are not limited to:

2.29.2.1. Home visitations services.

2.29.2.2. WIC.

2.29.2.3. Housing agencies.

2.29.2.4. Other services central to recovery and parenting.

14. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.30. to read:

2.30. The Contractor shall work with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

15. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.40. to read:

2.40. The Contractor shall ensure all sites are in compliance with confidentiality requirements, which include, but are not limited to:

2.40.1. Applicable federal and state laws.

2.40.2. HIPAA Privacy Rule.

2.40.3. 42 C.F.R Part 2.

16. Modify Exhibit A - Amendment #1, Scope of Services, Section 2, Scope of Work, Subsection 2.42.

to read:

2.42. The Contractor shall provide a written work plan to the Department for review and approval, ensuring the plan describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract. The Contractor shall provide monthly status reports based on work plan progress that includes, but is not limited to:

2.42.1.. Staff retained to support MAT at each site;

2.42.2. Number of prescribers waivered to prescribe buprenorphine at each site;

2.42.3. Outreach activities conducted by the Contractor and by each site;

2.42.4. Policies and practices established;

2.42.5. Encountered and foreseeable issues, along with actual or suggested resolutions;

2.42.6. Changes made to the initial work plan;

2.42.7. Training and technical assistance provided to or needed by each site; and

2.42.8. Other progress to date.

17. Modify Exhibit A - Amendment #1, Scope of Services, Section 3, Staffing, Subsection 3.5. to read:

3.5. RESERVED

18. Modify Exhibit A - Amendment #1, Scope of Services, Section 4, Training, Paragraph 4.2.3. to read:

4.2.3. RESERVED.

19. Modify Exhibit A - Amendment #1, Scope of Services, Section 4, Training, Section 4.3. to read:

4.3. RESERVED

20. Modify Exhibit A - Amendment #1, Scope of Services, Section 4, Training, Section 4.5. to read:

4.5. RESERVED

21. Modify Exhibit A - Amendment #1, Scope of Services, Section 4, Training, Section 4.7. to read:

4.7. The Contractor shall assist practice staff in attending externally provided formal trainings where appropriate.

22. Modify Exhibit A – Amendment #1, Scope of Services, Section 2, Scope of Work, by adding Subsection 4.8 to read:

4.8. The Contractor and all its sites shall report all critical incidents and sentinel events to the Department in writing as soon as possible and no more than 24 hours following the incident. The Contractor agrees that:

4.8.1. "Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to physical or mental health, safety, or well- being, including but not limited to:

4.8.1.1. Abuse;

4.8.1.2. Neglect;

4.8.1.3. Exploitation;

4.8.1.4. Rights violation;

4.8.1.5. Missing person;

4.8.1.6. Medical emergency;

4.8.1.7. Restraint; or

4.8.1.8. Medical error.

4.8.2. All contact with law enforcement shall be reported to the Department in writing as soon as possible and no more than 24 hours following the incident;

4.8.3. All media contacts shall be reported to the Department in writing as soon as possible and no more than 24 hours following the incident;

4.8.4. All sentinel events, involving any individual receiving services under this contract, shall be reported to the Department as follows:

4.8.4.1. "Sentinel events" as defined by the Department's Sentinel Event Reporting and Review policy is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

4.8.4.2. Upon discovering the event, the Contractor shall provide immediate verbal notification of the event to the Department, which shall include:

4.8.4.1. The reporting individual's name, phone number, and organization;

4.8.4.2. Name and date of birth of the individual(s) involved in the event;

4.8.4.3. Location, date, and time of the event;

4.8.4.4. Description of the event, including what, when, where, how the event happened, and other relevant information, as well as the identification of any other individuals involved;

4.8.4.5. Whether the police were involved due to a crime or suspected crime; and

4.8.4.6. The identification of any media that reported the event.

4.8.4.7. Within 72 hours of the sentinel event, the Contractor shall submit a completed "Sentinel Event Reporting Form" (February 2017), available at https://www.dhhs.nh.gov/dcbcs/documents/reporting-form.docx ~~to DS~~ the Department; and

4.8.4.8. Additional information on the event that is discovered after filing the form in Item 4.8.4.1.1.7. above shall be reported to the Department, in writing, as it becomes available or upon request of the Department.

23. Modify Exhibit A – Amendment #1, Scope of Services, Section 2, Scope of Work, by adding Subsection 4.9. to read:

    4.9. The Contractor shall report all Critical and Sentinel events as outlined in Subsection 4.8, to other agencies as required by law.

24. Modify Exhibit A – Amendment #1, Scope of Services, Section 2, Scope of Work, by adding Subsection 4.10. to read:

    4.10. The Contractor shall submit, and ensure all Sites submit, additional information regarding Critical and Sentinel events if required and as requested by the Department.

25. Modify Exhibit A – Amendment #1, Scope of Work, Section 2, Scope of Work, by adding Subsection 4.11. to read:

    4.11. The Contractor shall submit a sustainability plan, to the Department for review and approval, at least three (3) months prior to the end of this contract.

26. Modify Exhibit A – Amendment #1, Scope of Services, Section 5, Reporting to read:

    5. Reporting and Data Collection

    5.1. The Contractor shall assist and ensure each site collects, reports and submits de-identified, aggregate patient data that includes, but is not limited to:

        5.1.1. Demographics and measures for all program participants, as identified by the Department.

        5.1.2. Number of people referred to or from local and regional Doorways, detailing Doorway and service.

        5.1.3. Federally-required data points specific to this funding opportunity, as identified by SAMHSA.

        5.1.4. The number of additional supports and services provided, by type of service and support.

    5.2. The Contractor, in collaboration with the Department, shall analyze and utilize data collected to promote quality improvement efforts of this project.

    5.3. The Contractor shall report all data in Section 5 to the Department for all sites in totality as well as individually in a format approved by the Department.

    5.4. The Contractor shall prepare and submit ad hoc data reports, respond to periodic surveys, and other data collection requests as deemed necessary by the Department and/or SAMHSA.

    5.5. The Contractor shall report on and submit all data points in Section 5, as requested by the Department, on the 20th day of each month, and send the results in de-identified, aggregate form to the Department using a Department-approved format.

    5.6. The Contractor must submit a final report to the Department within 45 days of

conclusion of the contract which includes, but is not limited to:

5.6.1. A summary of information detailing progress made toward completion of all aspects of the Scope of Services, including challenges encountered and actions taken;

5.6.2. Total of de-identified and aggregate data by Site and by program as a whole;

5.6.3. Demographics of participants;

5.6.4. Number of patients receiving MAT prior to program implementation compared to number of patients receiving MAT at end of Contract, including demographic (e.g., gender, age, race, ethnicity) and outcome data as appropriate;

5.6.5. Training and technical assistance provided; and

5.6.6. Other progress to date.

27. Modify Exhibit A – Amendment #1, Scope of Services, Section 6, Performance Measures to read:

6. Performance Measures

6.1. The following aggregate performance indicators are to be achieved annually and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Sites.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers, as reported by the Sites.

6.1.3. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from State Fiscal Year 2020 to State Fiscal Year 2021, as reported by the Sites.

6.2. Annually, the Contractor shall develop and submit to the Department, a corrective action plan, in a format approved by the Department, for any performance measure that was not achieved.

6.3. The Contractor shall collaborate with the Department on the development, reporting, and quality improvement efforts for additional performance measures and outcome indicators.

28. Modify Exhibit A – Amendment #1, Scope of Services, by adding Section 7, State Opioid Response (SOR) Grant Standards to read:

7. State Opioid Response (SOR) Grant Standards

7.1. In order to receive payments for services provided through SOR grant funded initiatives, the Contractor shall ensure each Site.

7.1.1. Establishes formal information sharing and referral agreements with all Doorways for substance use services that comply with all applicable confidentiality laws, including 42 CFR Part 2.

7.1.2. Completes client referrals to applicable Doorways for substance use services within two (2) business days of a client's admission to the program.

7.1.3. Only provides medical withdrawal management services to any individual supported by SOR Grant Funds if the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.

7.2. The Contractor shall ensure that only FDA-approved MAT for OUD is utilized.

7.3. The Contractor shall provide the Department with a budget narrative within thirty (30) days of the contract effective date.

7.4. The Contractor shall meet with the Department within sixty (60) days of the contract effective date to review contract implementation.

7.5. The Contractor shall provide the Department with timelines and implementation plans associated with SOR funded activities to ensure services are in place within thirty (30) days of the contract effective date.

7.6.1. If the Contractor is unable to offer services within the required timeframe, the Contractor shall submit an updated implementation plan to the Department for approval to outline anticipated service start dates.

7.6.2. The Department reserves the right to terminate the contract and liquidate unspent funds, if services are not in place within ninety (90) days of the contract effective date.

7.6. The Contractor shall assist clients with enrolling in public or private health insurance, if the client is determined eligible for such coverage and will have staff trained in Presumptive Eligibility for Medicaid.

7.7. The Contractor shall accept clients for MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.

7.8. The Contractor shall coordinate with the NH Ryan White HIV/AIDs program for clients identified as at risk of or with HIV/AIDS.

7.9. The Contractor shall ensure that all clients are regularly screened for, tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.

7.10. The Contractor shall collaborate with the Department to understand and comply with all appropriate DHHS, State of NH, SAMHSA, and other Federal terms, conditions, and requirement.

7.11. The Contractor shall attest the understanding that SOR grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. The Contractor agrees that:

7.11.1. Treatment in this context includes the treatment of opioid use disorder (OUD).

7.11.2. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.

7.11.3. This marijuana restriction applies to all subcontracts and memorandums of understanding (MOU) that receive SOR funding.

7.11.4. Attestations will be provided to the Contractor by the Department.

7.11.5. The Contractor shall complete and submit all attestations to the Department within thirty (30) days of contract approval.

7.12. The Contractor shall refer to Exhibit C for grant terms and conditions including, but not limited to:

7.12.1. Invoicing;

7.12.2. Funding restrictions; and

7.12.3. Billing.

29. Modify Exhibit B, Methods and Conditions Precedent to Payment by replacing in its entirety with Exhibit B, Amendment #1, Methods and Conditions Precedent to Payment in order to update references specific to grant funding, which is attached hereto and incorporated by reference herein.

30. Add Exhibit B-5, Amendment #2, SOR II which is attached hereto and incorporated by reference herein.

31. Add Exhibit B-6, Amendment #2, SOR II which is attached hereto and incorporated by reference herein.

New Hampshire Department of Health and Human Services
Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

All terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #2 remain in full force and effect. This amendment shall be retroactively effective to September 30, 2020 upon the date of Governor and Executive Council approval.

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

State of New Hampshire
Department of Health and Human Services

1/5/2021
Date

DocuSigned by:
Katja Fox
ED9D05B04C63442...
Name: Katja Fox
Title: Director

Mary Hitchcock Memorial Hospital

1/5/2021
Date

DocuSigned by:
Jennifer Lopez
0905364B233D4D8...
Name: Jennifer Lopez
Title: Director of Research Operations Finance

New Hampshire Department of Health and Human Services
Integrated Medication Assisted Treatment for
Pregnant and Postpartum Women

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

1/15/2021
Date

DocuSigned by:
D5CA9202E32C4AF...
Name: Catherine Pinos
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Methods and Conditions Precedent to Payment

1. This Agreement is funded by100% Federal funds from the State Opioid Response Grant, as awarded on 09/30/2018, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), CFDA #93.788, FAIN TI081685 and as awarded on 9/30/2020, by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, CFDA #93.788, FAIN TI080246.
2. For the purposes of this Agreement:
   2.1. The Department has identified the Contractor as a Subrecipient in accordance with 2 CFR 200.330.
   2.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
3. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this Agreement, and shall be in accordance with the approved line item, as specified in Exhibits B-1, Amendment #1, Budget through Exhibit B-6, Amendment #2, SOR II.
4. The Contractor shall seek reimbursement as follows:
   4.1. First, the Contractor shall charge the client's private insurance or or payor sources.
   4.2. Second, the Contractor shall charge Medicare.
   4.3. Third, the Contractor shall charge Medicaid enrolled individuals, as follows:
      4.3.1. Medicaid Care Management: If enrolled with a Managed Care Organization (MCO), the Contractor shall be paid in accordance with its contract with the MCO.
      4.3.2. Medicaid Fee for Service: The Contractor shall bill Medicaid for services on the Fee for Service (FFS) schedule.
   4.4. Fourth, the Contractor shall charge the client in accordance with the Sliding Fee Scale Program.
   4.5. Lastly, if any portion of the amount specified in the Sliding Fee Scale remains unpaid, charge the Department for the unpaid balance.
5. The Contractor shall submit an invoice in a form satisfactory to the State by the 25th working day of the following month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The Contractor shall ensure the invoice is completed, dated and returned to the Department in order to initiate payment. Invoices shall be net any

other revenue received towards the services billed in fulfillment of this agreement. The Contractor shall ensure:

5.1. Backup documentation includes, but is not limited to:

5.1.1. General Ledger showing revenue and expenses for the contract

5.1.2. Timesheets and/or time cards that support the hours employees worked for wages reported under this contract.

5.1.2.1. Per 45 CFR Part 75.430(i)(1) Charges to Federal awards for salaries and wages must be based on records that accurately reflect the work performed.

5.1.2.2. Attestation and time tracking templates are available upon request from the Department.

5.1.2.3. The Contractor shall hold all subcontractors to the same rules and regulations stated in this Exhibit B.

5.1.3. Invoices supporting expenses reported include, but are not limited to:

5.1.3.1. Unallowable expenses that include, but are not limited to:

5.1.3.1.1. Amounts belonging to other programs;

5.1.3.1.2. Amounts prior to effective date of contract;

5.1.3.1.3. Construction or renovation expenses;

5.1.3.1.4. Food or water for employees;

5.1.3.1.5. Directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana;

5.1.3.1.6. Fines, fees, or penalties; and

5.1.3.1.7. Per SAMSHA requirements, meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed $3.00 per

person for clients.

5.1.3.1.8. Cell phones and cell phone minutes for clients.

5.1.3.2. Receipts for expenses within the applicable state fiscal year

5.1.3.3. Cost center reports

5.1.3.4. Profit and loss report

5.1.3.5. Remittance Advices from the insurances billed. Remittance Advices do not need to be supplied with the invoice, but should be retained to be available upon request.

5.1.3.6. Information requested by the Department verifying allocation or off-set based on third party revenue received.

5.1.3.7. Summaries of patient services revenue and operating revenue and other financial information as requested by the Department.

6. The Contractor is responsible for reviewing, understanding, and complying with further restrictions included in the FOA.

7. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to melissa.girard@dhhs.nh.gov, or invoices may be mailed to:

   Financial Manager
   Department of Health and Human Services
   129 Pleasant Street
   Concord, NH 03301

8. The Contractor agrees that billing submitted for review after twenty (20) business days of the last day of the billing month may be subject to non-payment.

9. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available, subject to Paragraph 4 of the General Provisions (Form Number P-37) of this Agreement.

10. The final invoice shall be due to the State no later than forty (40) days after the contract completion date specified in Form P-37, General Provisions Block 1.7 Completion Date.

11. The Contractor must provide the services in Exhibit A, Scope of Services, in compliance with funding requirements.

12. The Contractor agrees that funding under this Agreement may be withheld, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit A Amendment #2 Scope of Services, including failure to submit required monthly and/or quarterly reports.

13. Notwithstanding paragraph 18 of the General Provisions 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.

14. Audits

14.1. The Contractor is required to submit an annual audit to the Department if **any** of the following conditions exist:

14.1.1. 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.

14.1.2. 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.

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

14.2. If Condition A exists, the Contractor shall submit an annual single audit performed by an independent Certified Public Accountant (CPA) to the Department 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.

14.3. 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.

14.4. Any Contractor that receives an amount equal to or greater than $250,000 from the Department during a single fiscal year, regardless of the funding source, may be required, at a minimum, to submit annual financial audits performed by an independent CPA if the Department's risk assessment determination indicates the Contractor is high-risk.

14.5. 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

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made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY21 09/30/20-06/30/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 462,237.00	$ 143,294.00	$ 605,531.00	$ -	$ -	$ -	$ 462,237.00	$ 143,294.00	$ 605,531.00
2. Employee Benefits	$ 133,784.00	$ 41,473.00	$ 175,257.00	$ -	$ -	$ -	$ 133,784.00	$ 41,473.00	$ 175,257.00
3. Consultants	$ 37,101.00	$ 11,501.00	$ 48,602.00	$ -	$ -	$ -	$ 37,101.00	$ 11,501.00	$ 48,602.00
4. Equipment:				$ -	$ -	$ -			
Rental				$ -	$ -	$ -			
Repair and Maintenance				$ -	$ -	$ -			
Purchase/Depreciation				$ -	$ -	$ -			
5. Supplies:	$ 7,718.00	$ 2,393.00	$ 10,111.00	$ -	$ -	$ -	$ 7,718.00	$ 2,393.00	$ 10,111.00
Educational				$ -	$ -	$ -			
Lab				$ -	$ -	$ -			
Pharmacy				$ -	$ -	$ -			
Medical				$ -	$ -	$ -			
Office				$ -	$ -	$ -			
6. Travel	$ 2,500.00	$ 775.00	$ 3,275.00	$ -	$ -	$ -	$ 2,500.00	$ 775.00	$ 3,275.00
7. Occupancy				$ -	$ -	$ -			
8. Current Expenses				$ -	$ -	$ -			
Telephone				$ -	$ -	$ -			
Postage				$ -	$ -	$ -			
Subscriptions				$ -	$ -	$ -			
Audit and Legal				$ -	$ -	$ -			
Insurance				$ -	$ -	$ -			
Board Expenses				$ -	$ -	$ -			
9. Software				$ -	$ -	$ -			
10. Marketing/Communications	$ 3,500.00	$ 1,085.00	$ 4,585.00	$ -	$ -	$ -	$ 3,500.00	$ 1,085.00	$ 4,585.00
11. Staff Education and Training	$ 5,000.00	$ 1,550.00	$ 6,550.00	$ -	$ -	$ -	$ 5,000.00	$ 1,550.00	$ 6,550.00
12. Subcontracts/Agreements	$ 35,182.00	$ 10,907.00	$ 46,089.00	$ -	$ -	$ -	$ 35,182.00	$ 10,907.00	$ 46,089.00
13. Other (specific details mandatory):				$ -	$ -	$ -			
				$ -	$ -	$ -			
				$ -	$ -	$ -			
				$ -	$ -	$ -			
TOTAL	$ 687,022.00	$ 212,978.00	$ 900,000.00	$ -	$ -	$ -	$ 687,022.00	$ 212,978.00	$ 900,000.00
Indirect As A Percent of Direct		31.0%							

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Contractor Initials

Date 1/5/2021

New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Contractor Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY22 07/01/21-09/29/21 (SORII)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct	Indirect	Total	Direct	Indirect	Total	Direct	Indirect	Total
1. Total Salary/Wages	$ 151,783.00	$ 47,053.00	$ 198,836.00	$ -	$ -	$ -	$ 151,783.00	$ 47,053.00	$ 198,836.00
2. Employee Benefits	$ 46,475.00	$ 14,407.00	$ 60,882.00	$ -	$ -	$ -	$ 46,475.00	$ 14,407.00	$ 60,882.00
3. Consultants	$ 15,872.00	$ 4,921.00	$ 20,793.00	$ -	$ -	$ -	$ 15,872.00	$ 4,921.00	$ 20,793.00
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ 1,300.00	$ 403.00	$ 1,703.00	$ -	$ -	$ -	$ 1,300.00	$ 403.00	$ 1,703.00
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 250.00	$ 78.00	$ 328.00	$ -	$ -	$ -	$ 250.00	$ 78.00	$ 328.00
7. Occupancy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 600.00	$ 186.00	$ 786.00	$ -	$ -	$ -	$ 600.00	$ 186.00	$ 786.00
11. Staff Education and Training	$ 1,000.00	$ 310.00	$ 1,310.00	$ -	$ -	$ -	$ 1,000.00	$ 310.00	$ 1,310.00
12. Subcontracts/Agreements	$ 11,727.00	$ 3,635.00	$ 15,362.00	$ -	$ -	$ -	$ 11,727.00	$ 3,635.00	$ 15,362.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 229,007.00	$ 70,993.00	$ 300,000.00	$ -	$ -	$ -	$ 229,007.00	$ 70,993.00	$ 300,000.00
Indirect As A Percent of Direct		31.0%							

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Contractor Initials
1/5/2021
Date

State of New Hampshire

Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MARY HITCHCOCK MEMORIAL HOSPITAL is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on August 07, 1889. 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: **68517**

Certificate Number: **0004905338**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 1st day of May A.D. 2020.

William M. Gardner

Secretary of State

Dartmouth-Hitchcock
Dartmouth-Hitchcock Medical Center
1 Medical Center Drive
Lebanon, NH 03756
Dartmouth-Hitchcock.org

Dartmouth-Hitchcock

CERTIFICATE OF VOTE/AUTHORITY

I, Edward H. Stansfield, III, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

1. I am the duly elected Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital;
2. The following is a true and accurate excerpt from the December 7th, 2012 Bylaws of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital:

   ARTICLE I – Section A. Fiduciary Duty. Stewardship over Corporate Assets

   "In exercising this [fiduciary] duty, the Board may, consistent with the Corporation's Articles of Agreement and these Bylaws, delegate authority to the Board of Governors, Board Committees and various officers the right to give input with respect to issues and strategies, incur indebtedness, make expenditures, enter into contracts and agreements and take such other binding actions on behalf of the Corporation as may be necessary or desirable."
3. Article I – Section A, as referenced above, provides authority for the chief officers, including the Chief Executive Officer, the Chief Clinical Officer, and other officers, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital to sign and deliver, either individually or collectively, on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.
4. Edward J. Merrens, MD is the Chief Clinical Officer of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital and therefore has the authority to enter into contracts and agreements on behalf of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital.

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 21 day of December, 2020.

Edward H. Stansfield, III, Board Chair

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 21st day of December, 2020, by Edward H. Stansfield, III.

LAURA K. RONDEAU
NOTARY PUBLIC
STATE OF NEW HAMPSHIRE
MY COMMISSION EXPIRES APRIL 19, 2022

Notary Public
My Commission Expires: April 19, 2022

Dartmouth-Hitchcock

Susan Reeves, EdD, RN, CENP

Executive Vice President, Dartmouth-Hitchcock Medical Center
System Chief Nursing Executive, Dartmouth-Hitchcock Health
Clinical Professor, Department of Community and Family Medicine

Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-0001
Phone (603) 650-5606
Dartmouth-Hitchcock.org

December 30, 2020

Attorney General
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Attorney General:

At the request of the State of New Hampshire, I am writing to notify you that, as noted in the attached Delegation of Signature Authority from August 25, 2020, in her role as Director of Research Operations and Finance, Jennifer J. Lopez, CSSBB, continues to have authority to sign contracts on behalf of Dartmouth-Hitchcock which have a funding amount not to exceed $1,000,000 and which have a term of less than five (5) years.

Please do not hesitate to reach out should you require further documentation.

Sincerely,

Susan Reeves RN

Susan A. Reeves, EdD, RN, CENP
Executive Vice President, Dartmouth-Hitchcock Medical Center
System Chief Nursing Executive, Dartmouth-Hitchcock Health

DELEGATION OF SIGNATURE AUTHORITY

RESEARCH CONTRACTS AND SPONSORED PROGRAM AGREEMENTS

The authority to sign contracts, grants, consortia, center, cooperative and other research and sponsored program agreements (collectively referred to herein as "Contracts") on behalf of Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic (together, "Dartmouth-Hitchcock") is delegated by the Chief Executive Officer of Dartmouth-Hitchcock to the Executive Vice President, Dartmouth-Hitchcock Medical Center (and, in her absence or unavailability, to another Chief Officer of Dartmouth - Hitchcock).

The authority to sign Contracts on behalf of Dartmouth-Hitchcock *which have a funding amount not to exceed $1,000,000 and which have a term of less than five (5) years* is hereby sub- delegated by the Executive Vice President, DHMC to the Director of Research Operations and Finance. Notwithstanding, this authority shall not include signing Contracts for: a) procurement and sales of goods and services; b) banking and financial transactions; c) other binding contractual relationships, and d) services agreements (collectively referred to herein as "Other Contracts") as these terms are defined per the Dartmouth-Hitchcock Signature Authority-General Authority Policy and signing of all such Other Contracts shall comply with the Dartmouth-Hitchcock Signature Authority-General Authority Policy.

A Contract means an agreement between two or more persons that creates a legally binding obligation to do or not to do a thing. A Contract may be titled as an agreement, a memorandum of understanding, memorandum of agreement, a promise to pay. Dartmouth-Hitchcock, or may use other terminology. A Contract may or may not involve the payment of money to Dartmouth-Hitchcock.

Additional sub-delegation of signature authority may only be made upon written authorization of the Executive Vice President, DHMC.

An individual with delegated/sub-delegated signature authority who signs a Contract on behalf of Dartmouth-Hitchcock has the responsibility to ensure that the Contract follows Dartmouth-Hitchcock policies, rules and guidelines and all applicable laws and regulations.

The effective date of this sub-delegation shall be the date executed by the Executive Vice President, DHMC, as set forth below, and shall continue until revocation by the Executive Vice President, DHMC.

Susan A. Reeves, RN

Susan A. Reeves, EdD, RN
Executive Vice President, DHMC

Dated: August 25, 2020

CERTIFICATE OF INSURANCE

DATE: July 1, 2020

COMPANY AFFORDING COVERAGE
Hamden Assurance Risk Retention Group, Inc.
P.O. Box 1687
30 Main Street, Suite 330
Burlington, VT 05401

INSURED
Dartmouth-Hitchcock Clinic
One Medical Center Drive
Lebanon, NH 03756
(603)653-6850

This certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded by the policies below.

COVERAGES

The Policy listed below has been issued to the Named Insured above for the Policy Period notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued. The insurance afforded by the policy is subject to all the terms, exclusions and conditions of the policy. Limits shown may have been reduced by paid claims.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002020-A	07/01/2020	07/01/2021	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$100,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

DESCRIPTION OF OPERATIONS/ LOCATIONS/ VEHICLES/ SPECIAL ITEMS (LIMITS MAY BE SUBJECT TO RETENTIONS)

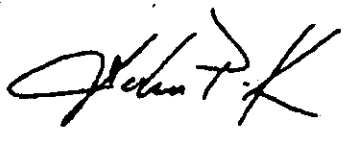
Certificate is issued as evidence of insurance only.

CERTIFICATE HOLDER

NH Dept of Health & Human Services
129 Pleasant Street
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVES



DARTHIT-01 ASTOBERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/29/2020

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

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

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: PHONE (A/C, No, Ext): (207) 829-3450 FAX (A/C, No): (207) 829-6350 E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	☐ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$ $ $ $ $ $ $
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ $ $ $ $
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE $	$ $ $
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N ☐ If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AG4061049	7/1/2020	7/1/2021	X PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

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

CERTIFICATE HOLDER

NH Dept. of Health & Human Services
129 Pleasant Street
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Dartmouth-Hitchcock

Mission, Vision, & Values

Our Mission

We advance health through research, education, clinical practice, and community partnerships, providing each person the best care, in the right place, at the right time, every time.

Our Vision

Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation.

Values

- Respect
- Integrity
- Commitment
- Transparency
- Trust
- Teamwork
- Stewardship
- Community

Dartmouth-Hitchcock Health and Subsidiaries

Report on Federal Awards in Accordance With the Uniform Guidance

June 30, 2019

EIN #02–0222140

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2019

Part I

Financial Statements and Schedule of Expenditures of Federal Awards

Report of Independent Auditors

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2019 and 2018, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the 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 the 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 our 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, we consider internal control relevant to the Health System'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 Health System'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.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Dartmouth-Hitchcock Health and its subsidiaries as of June 30, 2019 and 2018, and the results of their operations, changes in net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

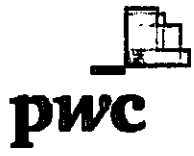
As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for revenue recognition from contracts with customers and the manner in which it presents net assets and reports certain aspects of its financial statements as a not-for-profit entity in 2019. Our opinion is not modified with respect to this matter.

Other Matters

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating 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 consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of its operations, changes in net assets and cash flows of the individual companies and is not a required part of the consolidated financial statements. Accordingly, we do not express an opinion on the financial position, results of operations, changes in net assets and cash flows of the individual companies.

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards for the year ended June 30, 2019 is presented for purposes of additional analysis as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and is not a required part of the consolidated financial statements. The information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In



our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 26, 2019 on our consideration of the Health System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters for the year ended June 30, 2019. The purpose of that report is solely 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 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 the Health System's internal control over financial reporting and compliance.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2019

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 143,587	$ 200,169
Patient accounts receivable, net of estimated uncollectible of $132,228 at June 30, 2018 (Note 4)	221,125	219,228
Prepaid expenses and other current assets	95,495	97,502
Total current assets	460,207	516,899
Assets limited as to use (Notes 5 and 7)	876,249	706,124
Other investments for restricted activities (Notes 5 and 7)	134,119	130,896
Property, plant, and equipment, net (Note 6)	621,256	607,321
Other assets	124,471	108,785
Total assets	$ 2,216,302	$ 2,070,025
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 10,914	$ 3,464
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,468	3,311
Accounts payable and accrued expenses (Note 13)	113,817	95,753
Accrued compensation and related benefits	128,408	125,576
Estimated third-party settlements (Note 4)	41,570	41,141
Total current liabilities	298,177	269,245
Long-term debt, excluding current portion (Note 10)	752,180	752,975
Insurance deposits and related liabilities (Note 12)	58,407	55,516
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	281,009	242,227
Other liabilities	124,136	88,127
Total liabilities	1,513,909	1,408,090
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Net assets without donor restrictions (Note 9)	559,933	524,102
Net assets with donor restrictions (Notes 8 and 9)	142,460	137,833
Total net assets	702,393	661,935
Total liabilities and net assets	$ 2,216,302	$ 2,070,025

The accompanying notes are an integral part of these consolidated financial statements.

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Operating revenue and other support		
Patient service revenue	$ 1,999,323	$ 1,899,095
Provision for bad debts (Notes 2 and 4)	-	47,367
Net patient service revenue	1,999,323	1,851,728
Contracted revenue (Note 2)	75,017	54,969
Other operating revenue (Notes 2 and 5)	210,698	148,946
Net assets released from restrictions	14,105	13,461
Total operating revenue and other support	2,299,143	2,069,104
Operating expenses		
Salaries	1,062,551	989,263
Employee benefits	251,591	229,683
Medical supplies and medications	407,875	340,031
Purchased services and other	323,435	291,372
Medicaid enhancement tax (Note 4)	70,061	67,692
Depreciation and amortization	88,414	84,778
Interest (Note 10)	25,514	18,822
Total operating expenses	2,229,441	2,021,641
Operating income (loss)	69,702	47,463
Nonoperating gains (losses)		
Investment income, net (Note 5)	40,052	40,387
Other losses, net (Note 10)	(3,562)	(2,908)
Loss on early extinguishment of debt	(87)	(14,214)
Loss due to swap termination	-	(14,247)
Total nonoperating gains, net	36,403	9,018
Excess of revenue over expenses	$ 106,105	$ 56,481

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Operations and Changes in Net Assets
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Net assets without donor restrictions		
Excess of revenue over expenses	$ 106,105	$ 56,481
Net assets released from restrictions	1,769	16,313
Change in funded status of pension and other postretirement benefits (Note 11)	(72,043)	8,254
Other changes in net assets	-	(185)
Change in fair value of interest rate swaps (Note 10)	-	4,190
Change in interest rate swap effectiveness	-	14,102
Increase in net assets without donor restrictions	35,831	99,155
Net assets with donor restrictions		
Gifts, bequests, sponsored activities	17,436	14,171
Investment income, net	2,682	4,354
Net assets released from restrictions	(15,874)	(29,774)
Contribution of assets with donor restrictions from acquisition	383	-
Increase (decrease) in net assets with donor restrictions	4,627	(11,249)
Change in net assets	40,458	87,906
Net assets		
Beginning of year	661,935	574,029
End of year	$ 702,393	$ 661,935

The accompanying notes are an integral part of these consolidated financial statements.

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Statements of Cash Flows
Years Ended June 30, 2019 and 2018

(in thousands of dollars)	2019	2018
Cash flows from operating activities		
Change in net assets	$ 40,458	$ 87,906
Adjustments to reconcile change in net assets to net cash provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	-	(4,897)
Provision for bad debt	-	47,367
Depreciation and amortization	88,770	84,947
Change in funded status of pension and other postretirement benefits	72,043	(8,254)
(Gain) on disposal of fixed assets	(1,101)	(125)
Net realized gains and change in net unrealized gains on investments	(31,397)	(45,701)
Restricted contributions and investment earnings	(2,292)	(5,460)
Proceeds from sales of securities	1,167	1,531
Loss from debt defeasance	-	14,214
Changes in assets and liabilities		
Patient accounts receivable, net	(1,803)	(29,335)
Prepaid expenses and other current assets	2,149	(8,299)
Other assets, net	(9,052)	(11,665)
Accounts payable and accrued expenses	17,898	19,693
Accrued compensation and related benefits	2,335	10,665
Estimated third-party settlements	429	13,708
Insurance deposits and related liabilities	2,378	4,556
Liability for pension and other postretirement benefits	(33,104)	(32,399)
Other liabilities	12,267	(2,421)
Net cash provided by operating and nonoperating activities	161,145	136,031
Cash flows from investing activities		
Purchase of property, plant, and equipment	(82,279)	(77,598)
Proceeds from sale of property, plant, and equipment	2,188	-
Purchases of investments	(361,407)	(279,407)
Proceeds from maturities and sales of investments	219,996	273,409
Cash received through acquisition	4,863	-
Net cash used in investing activities	(216,639)	(83,596)
Cash flows from financing activities		
Proceeds from line of credit	30,000	50,000
Payments on line of credit	(30,000)	(50,000)
Repayment of long-term debt	(29,490)	(413,104)
Proceeds from issuance of debt	26,338	507,791
Repayment of interest rate swap	-	(16,019)
Payment of debt issuance costs	(228)	(4,892)
Restricted contributions and investment earnings	2,292	5,460
Net cash (used in) provided by financing activities	(1,088)	79,236
(Decrease) increase in cash and cash equivalents	(56,582)	131,671
Cash and cash equivalents		
Beginning of year	200,169	68,498
End of year	$ 143,587	$ 200,169
Supplemental cash flow information		
Interest paid	$ 23,977	$ 18,029
Net assets acquired as part of acquisition, net of cash aquired	(4,863)	-
Noncash proceeds from issuance of debt	-	137,281
Use of noncash proceeds to refinance debt	-	137,281
Construction in progress included in accounts payable and accrued expenses	1,546	1,569
Equipment acquired through issuance of capital lease obligations	-	17,670
Donated securities	1,167	1,531

The accompanying notes are an integral part of these consolidated financial statements.

1. Organization and Community Benefit Commitments

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of the following entities: Dartmouth-Hitchcock Clinic and Subsidiaries (DHC), Mary Hitchcock Memorial Hospital and Subsidiaries (MHMH), (DHC and MHMH together are referred to as D-H), The New London Hospital Association and Subsidiaries (NLH), Windsor Hospital Corporation (d/b/a Mt. Ascutney Hospital and Health Center) and Subsidiaries (MAHHC), Cheshire Medical Center and Subsidiaries (Cheshire), Alice Peck Day Memorial Hospital and, effective July 1, 2018, Subsidiary (APD), and the Visiting Nurse and Hospice for Vermont and New Hampshire and Subsidiaries (VNH). The "Health System" consists of D-HH, its members and their subsidiaries.

The Health System currently operates one tertiary, one community and three acute care (critical access) hospitals in New Hampshire (NH) and Vermont (VT). One facility provides inpatient and outpatient rehabilitation medicine and long-term care. The Health System also operates multiple physician practices, a nursing home, a continuing care retirement community, and a home health and hospice service. The Health System operates a graduate level program for health professions and is the principal teaching affiliate of the Geisel School of Medicine (Geisel), a component of Dartmouth College.

D-HH, Dartmouth-Hitchcock Clinic, Mary Hitchcock Memorial Hospital, The New London Hospital Association, Cheshire Medical Center, and Alice Peck Day Memorial Hospital are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Windsor Hospital Corporation and the Visiting Nurse and Hospice of VT and NH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

Community Benefits

The mission of the Health System is to advance health through clinical practice and community partnerships, research and education, providing each person the best care, in the right place, at the right time, every time.

Consistent with this mission, the Health System provides high quality, cost effective, comprehensive, and integrated healthcare to individuals, families, and the communities it serves regardless of a patient's ability to pay. The Health System actively supports community-based healthcare and promotes the coordination of services among healthcare providers and social services organizations. In addition, the Health System also seeks to work collaboratively with other area healthcare providers to improve the health status of the region. As a component of an integrated academic medical center, the Health System provides significant support for academic and research programs.

Certain member hospitals of the Health System file annual Community Benefits Reports with the State of NH which outline the community and charitable benefits each provides. VT hospitals are not required by law to file a state community benefit report. The categories used in the Community Benefit Reports to summarize these benefits are as follows:

- *Community Health Services* include activities carried out to improve community health and could include community health education (such as classes, programs, support groups, and materials that promote wellness and prevent illness), community-based clinical services (such as free clinics and health screenings), and healthcare support services (enrollment assistance in public programs, assistance in obtaining free or reduced costs medications, telephone information services, or transportation programs to enhance access to care, etc.).

- *Health Professions Education* includes uncompensated costs of training medical students, Residents, nurses, and other health care professionals.

- *Subsidized health services* are services provided by the Health System, resulting in financial losses that meet the needs of the community and would not otherwise be available unless the responsibility was assumed by the government.

- *Research support and other grants* represent costs in excess of awards for numerous health research and service initiatives awarded to the organizations within the Health System.

- *Financial Contributions* include financial contributions of cash, as well as in-kind contributions such as time, supplies, and expertise to local organizations to address community health needs.

- *Community-Building Activities* include expenses incurred to support the development of programs and partnerships intended to address public health challenges as well as social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement.

- *Community Benefit Operations* includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.

- *Charity Care and Costs of Government Sponsored Health Care* includes losses, at-cost, incurred by providing health care services to persons qualifying for hospital financial assistance programs, and uncompensated costs of providing health care services to patients who are Medicaid Beneficiaries.

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2018 was approximately $139,683,000. The 2019 Community Benefits Reports are expected to be filed in February 2020.

The following table summarizes the value of the community benefit initiatives outlined in the Health System's most recently filed Community Benefit Reports for the year ended June 30, 2018:

(in thousands of dollars)

Government-sponsored healthcare services	$	246,064
Health professional education		33,067
Charity care		13,243
Subsidized health services		11,993
Community health services		6,570
Research		5,969
Community building activities		2,540
Financial contributions		2,360
Community benefit operations		1,153
Total community benefit value	$	322,959

2. Summary of Significant Accounting Policies

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954, *Healthcare Entities*, which addresses the accounting for healthcare entities. The net assets, revenue, expenses, and gains and losses of healthcare entities are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets without donor restrictions are amounts not subject to donor-imposed stipulations and are available for operations. Net assets with donor restrictions are those whose use has been limited by donors to a specific time period or purpose, or whose use has been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

Use of Estimates

The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America 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 dates of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting periods. The most significant areas that are affected by the use of estimates include implicit and explicit pricing concessions, valuation of certain investments, estimated third-party settlements, insurance reserves, and pension obligations. Actual results may differ from those estimates.

Excess of Revenue Over Expenses

The consolidated statements of operations and changes in net assets include the excess of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on investments of net assets without donor restrictions, which are utilized to provide charity and other operational support. Peripheral activities, including contribution of net assets without donor restrictions from acquisitions, loss on early extinguishment of debt, loss due to swap termination, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

Changes in net assets without donor restrictions which are excluded from the excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets), change in funded status of pension and other postretirement benefit plans, and the effective portion of the change in fair value of interest rate swaps.

Charity Care

The Health System provides care to patients who meet certain criteria under their financial assistance policies without charge or at amounts less than their established rates. Because the Health System does not anticipate collection of amounts determined to qualify as charity care, they are not reported as revenue.

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. The amount of charges for implicit price concessions is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 4).

Patient Service Revenue
The Health System applies the accounting provisions of ASC 606, *Revenue from Contracts with Customers* (ASC 606). Patient service revenue is reported at the amount of consideration to which the Health System expects to be entitled from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and implicit pricing concessions. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 4).

Contracted Revenue
The Health System has various Professional Service Agreements (PSAs), pursuant to which certain organizations purchase services of personnel employed by the Health System and also lease space and equipment. Revenue pursuant to these PSAs and certain facility and equipment leases and other professional service contracts have been classified as contracted revenue in the accompanying consolidated statements of operations and changes in net assets.

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. Other revenue primarily consists of revenue from retail pharmacy, which the Health System records as customer revenues in the amounts that reflect the consideration to which it expects to be entitled in exchange for the prescription. Other revenue also includes joint operating agreements, grant revenue, cafeteria sales and other support service revenue.

Cash Equivalents
Cash equivalents include investments in highly liquid investments with maturities of three months or less when purchased, excluding amounts where use is limited by internal designation or other arrangements under trust agreements or by donors.

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/commingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the excess of revenues over expenses. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (Note 7).

Investments in pooled/commingled investment funds, private equity funds and hedge funds that represent investments where the Health System owns shares or units of funds rather than the underlying securities in that fund are valued using the equity method of accounting with changes in value recorded in the excess of revenues over expenses. All investments, whether held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheet dates on a nondistressed basis.

Certain members of the Health System are partners in a NH general partnership established for the purpose of operating a master investment program of pooled investment accounts. Substantially all of the Health System's board-designated and assets with donor restrictions, such as endowment funds, were invested in these pooled funds by purchasing units based on the market value of the pooled funds at the end of the month prior to receipt of any new additions to the funds. Interest, dividends, and realized and unrealized gains and losses earned on pooled funds are allocated monthly based on the weighted average units outstanding at the prior month-end.

Investment income or losses (including change in unrealized and realized gains and losses on investments, change in value of equity method investments, interest, and dividends) are included in the excess of revenue over expenses and classified as nonoperating gains and losses, unless the income or loss is restricted by donor or law (Note 9).

Fair Value Measurement of Financial Instruments
The Health System estimates fair value based on a valuation framework that uses a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of fair value hierarchy, as defined by ASC 820, *Fair Value Measurements and Disclosures*, are described below:

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.
Level 2	Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.
Level 3	Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

The Health System applies the accounting provisions of Accounting Standards Update (ASU) 2009-12, *Investments in Certain Entities That Calculate Net Asset Value per Share (or its Equivalent)* (ASU 2009-12). ASU 2009-12 allows for the estimation of fair value of investments for which the investment does not have a readily determinable fair value, to use net asset value (NAV) per share or its equivalent as a practical expedient, subject to the Health System's ability to redeem its investment.

The carrying amount of patient accounts receivable, prepaid and other current assets, accounts payable and accrued expenses approximates fair value due to the short maturity of these instruments.

Property, Plant, and Equipment
Property, plant, and equipment, and other real estate are stated at cost at the time of purchase or fair value at the time of donation, less accumulated depreciation. The Health System's policy is to capitalize expenditures for major improvements and to charge expense for maintenance and repair expenditures which do not extend the lives of the related assets. The provision for depreciation has been determined using the straight-line method at rates which are intended to amortize the cost of assets over their estimated useful lives which range from 10 to 40 years for buildings and improvements, 2 to 20 years for equipment, and the shorter of the lease term, or 5 to 12 years, for leasehold improvements. Certain software development costs are amortized using the straight-line method over a period of up to 10 years. Net interest cost incurred on borrowed funds during the

period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

The fair value of a liability for legal obligations associated with asset retirements is recognized in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. When a liability is initially recorded, the cost of the asset retirement obligation is capitalized by increasing the carrying amount of the related long-lived asset. Over time, the liability is accreted to its present value each period and the capitalized cost associated with the retirement is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the actual cost to settle the asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations and changes in net assets.

Gifts of capital assets such as land, buildings, or equipment are reported as support, and excluded from the excess of revenue over expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of capital 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 capital assets are reported as restricted support. Absent explicit donor stipulations about how long those capital assets must be maintained, expirations of donor restrictions are reported when the donated or acquired capital assets are placed in service.

Bond Issuance Costs
Bond issuance costs, classified on the consolidated balance sheets within long-term debt, are amortized over the term of the related bonds. Amortization is recorded within interest expense in the consolidated statements of operations and changes in net assets using the straight-line method which approximates the effective interest method.

Intangible Assets and Goodwill
The Health System records within other assets on the consolidated balance sheets goodwill and intangible assets such as trade names and leases-in-place. The Health System considers trade names and goodwill to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values exceed their fair values. The Health System has recorded $10,524,000 and $2,462,000 as intangible assets associated with its affiliations as of June 30, 2019 and 2018, respectively.

Derivative Instruments and Hedging Activities
The Health System applies the provisions of ASC 815, *Derivatives and Hedging*, to its derivative instruments, which require that all derivative instruments be recorded at their respective fair values in the consolidated balance sheets.

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets, specific firm commitments or forecasted transactions. The Health System also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly

effective in offsetting changes in variability of cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in net assets without donor restrictions until earnings are affected by the variability in cash flows of the designated hedged item. The ineffective portion of the change in fair value of a cash flow hedge is reported in excess of revenue over expenses in the consolidated statements of operations and changes in net assets.

The Health System discontinues hedge accounting prospectively when it is determined: (a) the derivative is no longer effective in offsetting changes in the cash flows of the hedged item; (b) the derivative expires or is sold, terminated, or exercised; (c) the derivative is undesignated as a hedging instrument because it is unlikely that a forecasted transaction will occur; (d) a hedged firm commitment no longer meets the definition of a firm commitment; and (e) management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued, the Health System continues to carry the derivative at its fair value on the consolidated balance sheets and recognizes any subsequent changes in its fair value in excess of revenue over expenses.

Gifts

Gifts without donor restrictions are recorded net of related expenses as nonoperating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported 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 and changes in net assets as net assets released from restrictions.

Recently Issued Accounting Pronouncements

In May 2014, the FASB issued ASU 2014-09 - *Revenue from Contracts with Customers (ASC 606)* and in August 2015, the FASB amended the guidance to defer the effective date of this standard by one year. ASU 2014-09 affects any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards. The core principle of the guidance in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The Health System adopted ASU 2014-09 effective July 1, 2018 under the modified retrospective method, and has provided the new disclosures required post implementation. For example, patient accounts receivable are shown net of the allowance for doubtful accounts of approximately $132,228,000 as of June 30, 2018 on the consolidated balance sheet. If an allowance for doubtful accounts had been presented as of June 30, 2019, it would have been approximately $121,544,000. While the adoption of ASU 2014-09 has had a material effect on the presentation of revenues in the Health System's consolidated statements of operations and changes in net assets, and has had an impact on certain disclosures, it has not materially impacted the financial position, results of operations or cash flows. Refer to Note 4, Patient Service Revenue and Accounts Receivable, for further details.

In February 2016, the FASB issued ASU 2016-02 – *Leases (Topic 842)*, which requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments, on its balance sheet. The standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. The guidance also expands the required quantitative and qualitative disclosures surrounding leases. The ASU is effective for fiscal years beginning after December 15, 2018, or fiscal year 2020 for the Health System. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01- *Recognition and Measurement of Financial Assets and Financial Liabilities*, which address certain aspects of recognition, measurement, presentation and disclosure of financial instruments. This guidance allows an entity to choose, investment-by-investment, to report an equity investment that neither has a readily determinable fair value, nor qualifies for the practical expedient for fair value estimation using NAV, at its cost minus impairment (if any), plus or minus changes resulting from observable price changes in orderly transactions for the identical or similar investment of the same issue. Impairment of such investments must be assessed qualitatively at each reporting period. Entities must disclose their financial assets and liabilities by measurement category and form of asset either on the face of the balance sheet or in the accompanying notes. The ASU is effective for annual reporting periods beginning after December 15, 2018 or fiscal year 2020 for the Health System. The provision to eliminate the requirement to disclose the fair value of financial instruments measured at cost (such as the fair value of debt) was early adopted during the year ended June 30, 2017.

In August 2016, the FASB issued ASU 2016-14 - *Presentation of Financial Statements for Not-for-Profit Entities*. The new pronouncement amends certain financial reporting requirements for not-for-profit entities. It reduces the number of classes of net assets from three to two: net assets with donor restrictions includes amount previously disclosed as both temporarily and permanently restricted net assets, net assets without donor restrictions includes amounts previously disclosed as unrestricted net assets. It expands the disclosure of expenses by both natural and functional classification. It adds quantitative and qualitative disclosures about liquidity and availability of resources. The ASU is effective for the Health System for the year ending June 30, 2019. The Health System has adopted this ASU on a retrospective basis, except for the presentation of expenses based on natural and functional classification and the discussion of liquidity, as permitted in the ASU. Please refer to Note 14, Functional Expenses, and Note 15, Liquidity.

In June 2018, the FASB issued ASU 2018-08, Not–for-Profit Entities (Topic 958), Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made. The new pronouncement was intended to assist entities in evaluating whether transactions should be accounted for as contributions or exchange transactions and whether a contribution is conditional. This ASU was effective for the Health System on July 1, 2018 on a modified prospective basis and did not have a significant impact on the consolidated financial statements of the Health System.

3. Acquisitions

Effective July 1, 2018, Alice Peck Day Memorial Hospital became the sole corporate member of APD LifeCare Center Inc. (LifeCare). LifeCare owns and operates Harvest Hill, an assisted living facility, the Woodlands, a residential living community and the Elizabeth S. Hughes Care Unit, which provides hospice care.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, Alice Peck Day Memorial Hospital recorded goodwill related to the acquisition of LifeCare of approximately $5,131,000. Restricted contribution income of $383,000 was recorded within net assets with donor restrictions in the accompanying consolidated statement of changes in net assets. Included in the transaction was LifeCare's cash balance of $4,863,000. No consideration was exchanged for the net assets assumed and acquisition costs were expensed as incurred. LifeCare's financial position, results of operations and changes in net assets are included in the consolidated financial statements as of and for the year ended June 30, 2019.

4. Patient Service Revenue and Accounts Receivable

The Health System reports patient service revenue at amounts that reflect the consideration to which it expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payers (including managed care payers and government programs), and others; and they include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Health System bills patients and third-party payers several days after the services were performed or shortly after discharge. Revenue is recognized as performance obligations are satisfied under contracts by providing healthcare services to patients.

The Health System determines performance obligations based on the nature of the services provided. Revenues for performance obligations satisfied over time are recognized based on actual charges incurred in relation to total expected charges as this method provides a reasonable estimate of the transfer of services over the term of performance obligations based on inputs needed to satisfy the obligations. Generally, performance obligations satisfied over time relate to patients receiving inpatient acute care services. For inpatient services, performance obligations are measured from admission to the point when there are no further services required for the patient, which is generally the time of discharge. For outpatient services and physician services, performance obligations are recognized at a point in time when the services are provided and no further patient services are deemed necessary.

Generally, the Health System's patient service performance obligations relate to contracts with a duration of less than one year, therefore the Health System has elected to apply the optional exemption provided in ASC 606-10-50-14a and, therefore, we are not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. This generally refers to inpatient services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

Established charges represent gross charges. They are not the same as actual pricing, and they generally do not reflect what a hospital is ultimately entitled to for services it provides. Therefore, they are not displayed in the Health System's consolidated statements of operations and changes in net assets.

Hospitals are paid amounts negotiated with insurance companies or set by government entities, which are typically less than established or standard charges. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts. Gross charges are what hospitals charge all patients prior to the application of contractual adjustments and implicit price concessions.

Explicit Pricing Concessions
Revenues for the Health System under the traditional fee-for service Medicare and Medicaid programs are based on prospectively determined rates per discharge or visit, reasonable (allowable) cost, or prospective rates per episodic period, depending on the type of provider.

- Inpatient acute care services provided to Medicare program beneficiaries are paid using the prospective payment system ("PPS") to determine rates-per-discharge. These rates vary according to a patient classification system ("DRG"), based on diagnostic, clinical and other factors. In addition, inpatient capital costs (depreciation and interest) are reimbursed by Medicare on the basis of a prospectively determined rate per discharge. Medicare outpatient services are paid on a prospective payment system, based on a pre-determined amount for each outpatient procedure (APC), subject to various mandated modifications. Retrospectively determined cost-based revenues under these programs, such as indirect medical education, direct graduate medical education, disproportionate share hospital, transplant services, and bad debt reimbursement are based on the hospital's cost reports and are estimated using historical trends and current factors. The Health System's payments for inpatient services rendered to New Hampshire ("NH") and Vermont ("VT") Medicaid beneficiaries are based on PPS, while outpatient services are reimbursed on a retrospective cost basis or fee schedules for NH beneficiaries. VT outpatient beneficiaries are paid on a prospective basis per outpatient procedure.

- Inpatient acute, swing, and outpatient services furnished by critical access hospitals ("CAH") are reimbursed by Medicare at 101% of reasonable costs, subject to 2% sequestration, excluding ambulance services and inpatient hospice care.

- Providers of home health services to patients eligible for Medicare home health benefits are paid on a prospective basis, with no retrospective settlement. The prospective payment is based on the scoring attributed to the acuity level of the patient at a rate determined by federal guidelines.

- Hospice services to patients eligible for Medicare hospice benefits are paid on a per diem basis, with no retrospective settlement, provided the aggregate annual Medicare reimbursement is below a predetermined aggregate capitated rate.

- The Health System's cost based services to Medicare and Medicaid are reimbursed during the year based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subject to audit of this report by Medicare and Medicaid auditors, as well as administrative and judicial review. Because the laws, regulations, and rule interpretations, governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change over time by material amounts.

- Revenues under Managed Care Plans (Plans) consist primarily of payment terms involving mutually agreed upon rates per diagnosis, discounted fee-for service rates, or similar contractual arrangements. These revenues are also subject to review and possible audit. The Plans are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustments in accordance with contractual terms in place with the Plans following their review and adjudication of each bill.

The Health System is not aware of any claims, disputes, or unsettled matters with any payer that would materially affect its revenues for which it has not adequately provided in the accompanying Health System's consolidated financial statements.

The Health System provides charity care to patients who are unable to pay for healthcare services they receive as determined by financial conditions. Patients who qualify receive partial or full adjustments to charges for services rendered. The Health System's policy is to treat amounts qualified as charity care as explicit price concessions and as such are not reported in net patient service revenue.

During fiscal year 2016, Vermont state legislation passed changes to the tax base for home health providers from 19.30% of core home health care services (primarily Medicaid services) with a cap of 6% of net patient service revenue to 3.63% of net patient revenue for fiscal year 2017 and fiscal year 2018. Home health provider tax paid, which is included in other operating expenses, was $628,000 and $737,000 in 2019 and 2018, respectively.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax (MET) Senate Bill 369. As part of the agreement, the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, and the State Rate Litigation. As part of the MET Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated funding mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services.

On May 22, 2018, the State of New Hampshire and all New Hampshire hospitals (NH Hospitals) signed a new settlement agreement and multi-year plan for Disproportionate Share Hospital (DSH) payments, with provisions to create alternative payments should there be federal changes to the DSH program by the United States Congress. The agreement may change or limit federal matching funds for MET when used to support DSH payments to hospitals and the Medicaid program, or change the definition of Uncompensated Care (UCC) for purposes of calculating DSH or other allowable uncompensated care payments. The term of the agreement is through state fiscal year (SFY) 2024. Under the agreement, the NH Hospitals forgo approximately $28,000,000 of DSH payment for SFY 2018 and 2019, in consideration of the State agreeing to form a pool of funds to make directed payments or otherwise increase rates to hospitals for SFY 2020 through 2024. The Federal share of payments to NH Hospitals are contingent upon the receipt of matching funds from Centers for Medicare & Medicaid Services (CMS) in the covered years. In the event that, due to changes in federal law, the State is unable to make payments in a way that ensures the federal matching funds are available, the Parties will meet and confer to negotiate in good faith an appropriate amendment to this agreement consistent with the intent of this agreement. The State is required to maintain the UCC Dedicated Fund pursuant to earlier agreements. The agreement prioritizes payments of funds to critical access hospitals at 75% of allowable UCC, the remainder thereafter is distributed to other NH Hospitals in proportion to their allowable uncompensated care amounts. During the term of this agreement, the NH Hospitals are barred from bringing a new claim in federal or state court or at Department of Revenue Administration (DRA) related to the constitutionality of MET.

During the years ended June 30, 2019 and 2018, the Health System received DSH payments of approximately, $69,179,000 and $66,383,000, respectively. DSH payments are subject to audit pursuant to the agreement with the state and therefore, for the years ended June 30, 2019 and 2018, the Health System recognized as revenue DSH receipts of approximately $64,864,000 and approximately $54,469,000, respectively.

During the years ended June 30, 2019 and 2018, the Health System recorded State of NH Medicaid Enhancement Tax ("MET") and State of VT Provider tax of $70,061,000 and $67,692,000, respectively. The taxes are calculated at 5.5% for NH and 6% for VT of certain net patient service revenues in accordance with instructions received from the States. The Provider taxes are included in operating expenses in the consolidated statements of operations and changes in net assets.

Implicit Price Concessions
Generally, patients who are covered by third-party payer contracts are responsible for related co-pays, co-insurance and deductibles, which vary depending on the contractual obligations of patients. The Health System also provides services to uninsured patients and offers those patients a discount from standard charges. The Health System estimates the transaction price for patients with co-pays, co-insurance, and deductibles and for those who are uninsured based on historical collection experience and current market conditions. The discount offered to uninsured patients reduces the transaction price at the time of billing. The uninsured and patient responsible accounts, net of discounts recorded, are further reduced through implicit price concessions based on historical collection trends for similar accounts and other known factors that impact the estimation process. Subsequent changes to the estimate of transaction price are generally recorded as adjustments to net patient service revenue in the period of change.

The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Health System expects to collect based on collection history with similar patients. Although outcomes vary, the Health System's policy is to attempt to collect amounts due from patients, including co-pays, co-insurance and deductibles due from insurance at the time of service while complying with all federal and state statutes and regulations, including but not limited to, the Emergency Medical Treatment and Active Labor Act (EMTALA). Through various systems and processes the Health System estimates Medicare and Medicaid net patient service revenue and cost report settlements and accrues final expected settlements. For filed cost reports, the accrual is recorded based on those filings, subsequent activity, and on historical trends and other relevant evidence. For periods in which a cost report is yet to be filed, accruals are based on estimates of what is expected to be reported, and any trends and relevant evidence. Cost reports generally must be filed within five months of the closing period.

Settlements with third-party payers for retroactive revenue adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely amount. These settlements are estimated based on the terms of the payment agreement with the payer, correspondence from the payer and historical settlement activity, including assessments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known, or as years are settled or are no longer subject to such audits, reviews or investigations. As of June 30, 2019 and 2018, the Health System had $52,470,000 and $52,041,000, respectively, reserved for estimated third-party settlements.

For the years ended June 30, 2019 and 2018, additional increases (decreases) in revenue of $1,800,000 and ($5,604,000), respectively, was recognized due to changes in its prior years related to estimated third-party settlements.

Net operating revenues for the hospital operations of the PPS and CAH, and other business segments consist primarily of patient service revenues, principally for patients covered by Medicare, Medicaid, managed care and other health plans as well as patients covered under the Health System's uninsured discount and charity care programs.

The table below shows the Health System's sources of net operating revenues presented at the net transaction price for the years ended June 30, 2019 and 2018.

	2019		
(in thousands of dollars)	**PPS**	**CAH**	**Total**
Hospital			
Medicare	$ 456,197	$ 72,193	$ 528,390
Medicaid	134,727	12,794	147,521
Commercial	746,647	64,981	811,628
Self pay	8,811	2,313	11,124
	1,346,382	152,281	1,498,663
Professional			
Professional	454,425	23,707	478,132
VNH			22,528
Other revenue			285,715
Total operating revenue and other support	$ 1,800,807	$ 175,988	$ 2,285,038

	2018		
(in thousands of dollars)	**PPS**	**CAH**	**Total**
Hospital			
Medicare	$ 432,251	$ 76,522	$ 508,773
Medicaid	117,019	10,017	127,036
Commercial	677,162	65,916	743,078
Self pay	10,687	2,127	12,814
	1,237,119	154,582	1,391,701
Professional			
Professional	412,605	24,703	437,308
VNH			22,719
Other revenue			203,915
Total operating revenue and other support	$ 1,649,724	$ 179,285	$ 2,055,643

Accounts Receivable

The principal components of patient accounts receivable as of June 30, 2019 and 2018 are as follows:

(in thousands of dollars)	2019	2018
Patient accounts recivable	$ 221,125	$ 351,456
Less: Allowance for doubtful accounts	-	(132,228)
Patient accounts receivable	$ 221,125	$ 219,228

The following table categorizes payors into four groups based on their respective percentages of gross patient accounts receivable as of June 30, 2019 and 2018:

	2019	2018
Medicare	34 %	34 %
Medicaid	12	14
Commercial	41	40
Self pay	13	12
Patient accounts receivable	100 %	100 %

5. Investments

The composition of investments at June 30, 2019 and 2018 is set forth in the following table:

(in thousands of dollars)	2019	2018
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 21,890	$ 8,558
U.S. government securities	91,492	50,484
Domestic corporate debt securities	196,132	109,240
Global debt securities	83,580	110,944
Domestic equities	167,384	142,796
International equities	128,909	106,668
Emerging markets equities	23,086	23,562
Real estate investment trust	213	816
Private equity funds	64,563	50,415
Hedge funds	32,287	32,831
	809,536	636,314
Investments held by captive insurance companies (Note 12)		
U.S. government securities	23,241	30,581
Domestic corporate debt securities	11,378	16,764
Global debt securities	10,080	4,513
Domestic equities	14,617	8,109
International equities	6,766	7,971
	66,082	67,938
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	631	1,872
Total assets limited as to use	876,249	706,124
Other investments for restricted activities		
Cash and short-term investments	6,113	4,952
U.S. government securities	32,479	28,220
Domestic corporate debt securities	29,089	29,031
Global debt securities	11,263	14,641
Domestic equities	20,981	20,509
International equities	15,531	17,521
Emerging markets equities	2,578	2,155
Real estate investment trust	-	954
Private equity funds	7,638	4,878
Hedge funds	8,414	8,004
Other	33	31
Total other investments for restricted activities	134,119	130,896
Total investments	$ 1,010,368	$ 837,020

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used for all debt securities and equity securities that are traded on active markets and are valued at prices that are readily available in those markets. The equity method is used when investments are made in pooled/commingled investment funds that represent investments where shares or units are owned of pooled funds rather than the underlying securities in that fund. These pooled/commingled funds make underlying investments in securities from the asset classes listed above. All investments, whether the fair value or equity method of accounting is used, are reported at what the Health System believes to be the amount that the Health System would expect to receive if it liquidated its investments at the balance sheets date on a nondistressed basis.

The following tables summarize the investments by the accounting method utilized, as of June 30, 2019 and 2018. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

	2019		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 28,634	$ -	$ 28,634
U.S. government securities	147,212	-	147,212
Domestic corporate debt securities	164,996	71,603	236,599
Global debt securities	55,520	49,403	104,923
Domestic equities	178,720	24,262	202,982
International equities	76,328	74,878	151,206
Emerging markets equities	1,295	24,369	25,664
Real estate investment trust	213	-	213
Private equity funds	-	72,201	72,201
Hedge funds	-	40,701	40,701
Other	33	-	33
	$ 652,951	$ 357,417	$ 1,010,368

	2018		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 15,382	$ -	$ 15,382
U.S. government securities	109,285	-	109,285
Domestic corporate debt securities	95,481	59,554	155,035
Global debt securities	49,104	80,994	130,098
Domestic equities	157,011	14,403	171,414
International equities	60,002	72,158	132,160
Emerging markets equities	1,296	24,421	25,717
Real estate investment trust	222	1,548	1,770
Private equity funds	-	55,293	55,293
Hedge funds	-	40,835	40,835
Other	31	-	31
	$ 487,814	$ 349,206	$ 837,020

Investment income is comprised of the following for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Net assets without donor restrictions		
Interest and dividend income, net	$ 11,333	$ 12,324
Net realized gains on sales of securities	17,419	24,411
Change in net unrealized gains on investments	12,283	4,612
	41,035	41,347
Net assets with donor restrictions		
Interest and dividend income, net	987	1,526
Net realized gains on sales of securities	2,603	1,438
Change in net unrealized gains on investments	(908)	1,390
	2,682	4,354
	$ 43,717	$ 45,701

For the years ended June 30, 2019 and 2018 investment income is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $983,000 and $960,000 and as nonoperating gains of approximately $40,052,000 and $40,387,000, respectively.

Private equity limited partnership shares are not eligible for redemption from the fund or general partner, but can be sold to third party buyers in private transactions that typically can be completed in approximately 90 days. It is the intent of the Health System to hold these investments until the fund has fully distributed all proceeds to the limited partners and the term of the partnership agreement expires. Under the terms of these agreements, the Health System has committed to contribute a specified level of capital over a defined period of time. Through June 30, 2019 and 2018, the Health System has committed to contribute approximately $164,319,000 and $137,219,000 to such funds, of which the Health System has contributed approximately $109,584,000 and $91,942,000 and has outstanding commitments of $54,735,000 and $45,277,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Land	$ 38,232	$ 38,058
Land improvements	42,607	42,295
Buildings and improvements	898,050	876,537
Equipment	888,138	818,902
Equipment under capital leases	15,809	20,966
	1,882,836	1,796,758
Less: Accumulated depreciation and amortization	1,276,746	1,200,549
Total depreciable assets, net	606,090	596,209
Construction in progress	15,166	11,112
	$ 621,256	$ 607,321

As of June 30, 2019, construction in progress primarily consists of an addition to the ambulatory surgical center located in Manchester, NH as well as renovations taking place at the various pharmacy locations to bring their facilities compliant with Regulation USP800. The estimated cost to complete the ambulatory surgical center at June 30, 2019 is approximately $59,000,000 over the next two fiscal years while the pharmacy renovation is estimated to cost approximately $6,300,000 over the next fiscal year.

The construction in progress reported as of June 30, 2018 for the building renovations taking place at the birthing pavilion in Lebanon, NH was completed during the first quarter of fiscal year 2019 and the information systems PeopleSoft project for Alice Peck Day Memorial Hospital and Cheshire was completed in the fourth quarter of fiscal year 2019.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $88,496,000 and $84,729,000 for 2019 and 2018, respectively.

7. Fair Value Measurements

The following is a description of the valuation methodologies for assets and liabilities measured at fair value on a recurring basis:

Cash and Short-Term Investments
Consists of money market funds and are valued at net asset value (NAV) reported by the financial institution.

Domestic, Emerging Markets and International Equities
Consists of actively traded equity securities and mutual funds which are valued at the closing price reported on an active market on which the individual securities are traded (Level 1 measurements).

U.S. Government Securities, Domestic Corporate and Global Debt Securities
Consists of U.S. government securities, domestic corporate and global debt securities, mutual funds and pooled/commingled funds that invest in U.S. government securities, domestic corporate and global debt securities. Securities are valued based on quoted market prices or dealer quotes where available (Level 1 measurement). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings and maturities, rather than on specific bids and offers for a designated security. Investments in mutual funds are measured based on the quoted NAV as of the close of business in the respective active market (Level 1 measurements).

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Health System believes its valuation methods are appropriate and consistent with 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.

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2019 and 2018:

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 28,634	$ -	$ -	$ 28,634	Daily	1
U.S. government securities	147,212	-	-	147,212	Daily	1
Domestic corporate debt securities	34,723	130,273	-	164,996	Daily–Monthly	1–15
Global debt securities	28,412	27,108	-	55,520	Daily–Monthly	1–15
Domestic equities	171,318	7,402	-	178,720	Daily–Monthly	1–10
International equities	76,295	33	-	76,328	Daily–Monthly	1–11
Emerging market equities	1,295	-	-	1,295	Daily–Monthly	1–7
Real estate investment trust	213	-	-	213	Daily–Monthly	1–7
Other	-	33	-	33	Not applicable	Not applicable
Total investments	488,102	164,849	-	652,951		
Deferred compensation plan assets						
Cash and short-term investments	2,952	-	-	2,952		
U.S. government securities	45	-	-	45		
Domestic corporate debt securities	4,932	-	-	4,932		
Global debt securities	1,300	-	-	1,300		
Domestic equities	22,403	-	-	22,403		
International equities	3,576	-	-	3,576		
Emerging market equities	27	-	-	27		
Real estate	11	-	-	11		
Multi strategy fund	48,941	-	-	48,941		
Guaranteed contract	-	-	89	89		
Total deferred compensation plan assets	84,187	-	89	84,276	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,301	9,301	Not applicable	Not applicable
Total assets	$ 572,289	$ 164,849	$ 9,390	$ 746,528		

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 15,382	$ -	$ -	$ 15,382	Daily	1
U.S. government securities	109,285	-	-	109,285	Daily	1
Domestic corporate debt securities	41,488	53,993	-	95,481	Daily–Monthly	1–15
Global debt securities	32,874	16,230	-	49,104	Daily–Monthly	1–15
Domestic equities	157,011	-	-	157,011	Daily–Monthly	1–10
International equities	59,924	78	-	60,002	Daily–Monthly	1–11
Emerging market equities	1,296	-	-	1,296	Daily–Monthly	1–7
Real estate investment trust	222	-	-	222	Daily–Monthly	1–7
Other	-	31	-	31	Not applicable	Not applicable
Total investments	417,482	70,332	-	487,814		
Deferred compensation plan assets						
Cash and short-term investments	2,637	-	-	2,637		
U.S. government securities	38	-	-	38		
Domestic corporate debt securities	3,749	-	-	3,749		
Global debt securities	1,089	-	-	1,089		
Domestic equities	18,470	-	-	18,470		
International equities	3,584	-	-	3,584		
Emerging market equities	28	-	-	28		
Real estate	9	-	-	9		
Multi strategy fund	46,680	-	-	46,680		
Guaranteed contract	-	-	86	86		
Total deferred compensation plan assets	76,284	-	86	76,370	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,374	9,374	Not applicable	Not applicable
Total assets	$ 493,766	$ 70,332	$ 9,460	$ 573,558		

The following table is a rollforward of financial instruments classified by the Health System within Level 3 of the fair value hierarchy defined above.

	2019		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,374	$ 86	$ 9,460
Net unrealized gains (losses)	(73)	3	(70)
Balances at end of year	$ 9,301	$ 89	$ 9,390

	2018		
(in thousands of dollars)	Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,244	$ 83	$ 9,327
Net unrealized gains	130	3	133
Balances at end of year	$ 9,374	$ 86	$ 9,460

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2019 and 2018.

8. Net Assets With Donor Restrictions

Net assets with donor restrictions are available for the following purposes at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Healthcare services	$ 20,140	$ 19,570
Research	26,496	24,732
Purchase of equipment	3,273	3,068
Charity care	12,494	13,667
Health education	19,833	18,429
Other	3,841	2,973
Investments held in perpetuity	56,383	55,394
	$ 142,460	$ 137,833

Income earned on donor restricted net assets held in perpetuity is available for these purposes.

9. Board Designated and Endowment Funds

Net assets include numerous funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

The Board of Trustees has interpreted the NH and VT Uniform Prudent Management of Institutional Funds Acts (UPMIFA or Act) for donor-restricted endowment funds as requiring the preservation of the original value of gifts, as of the gift date, to donor-restricted endowment funds, absent explicit donor stipulations to the contrary. The Health System's net assets with donor restrictions which are to be held in perpetuity consist of (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to be held in perpetuity, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund, if any. Collectively these amounts are referred to as the historic dollar value of the fund.

Net assets without donor restrictions include funds designated by the Board of Trustees to function as endowments and the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Net assets with donor restrictions that are temporary in nature, either restricted by time or purpose, include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the restrictions on these funds have been met, the funds are reclassified to net assets without donor restrictions.

In accordance with the Act, the Health System considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds: the duration and preservation of the fund; the purposes of the donor-restricted endowment fund; general economic conditions; the possible effect of inflation and deflation; the expected total return from income and the appreciation of investments; other resources available; and investment policies.

The Health System has endowment investment and spending policies that attempt to provide a predictable stream of funding for programs supported by its endowment while ensuring that the purchasing power does not decline over time. The Health System targets a diversified asset allocation that places emphasis on investments in domestic and international equities, fixed income, private equity, and hedge fund strategies to achieve its long-term return objectives within prudent risk constraints. The Health System's Investment Committee reviews the policy portfolio asset allocations, exposures, and risk profile on an ongoing basis.

The Health System, as a policy, may appropriate for expenditure or accumulate so much of an endowment fund as the institution determines is prudent for the uses, benefits, purposes, and duration for which the endowment is established, subject to donor intent expressed in the gift instrument and the standard of prudence prescribed by the Act.

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2019 and 2018.

Endowment net asset composition by type of fund consists of the following at June 30, 2019 and 2018:

	2019		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 78,268	$ 78,268
Board-designated endowment funds	31,421	-	31,421
Total endowed net assets	$ 31,421	$ 78,268	$ 109,689

	2018		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Donor-restricted endowment funds	$ -	$ 78,197	$ 78,197
Board-designated endowment funds	29,506	-	29,506
Total endowed net assets	$ 29,506	$ 78,197	$ 107,703

Changes in endowment net assets for the years ended June 30, 2019 and 2018 are as follows:

	2019		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 29,506	$ 78,197	$ 107,703
Net investment return	1,184	2,491	3,675
Contributions	804	1,222	2,026
Transfers	(73)	(1,287)	(1,360)
Release of appropriated funds	-	(2,355)	(2,355)
Balances at end of year	$ 31,421	$ 78,268	$ 109,689

	2018		
(in thousands of dollars)	Without Donor Restrictions	With Donor Restrictions	Total
Balances at beginning of year	$ 26,389	$ 75,457	$ 101,846
Net investment return	3,112	4,246	7,358
Contributions	-	1,121	1,121
Transfers	5	(35)	(30)
Release of appropriated funds	-	(2,592)	(2,592)
Balances at end of year	$ 29,506	$ 78,197	$ 107,703

10. Long-Term Debt

A summary of long-term debt at June 30, 2019 and 2018 is as follows:

(in thousands of dollars)	2019	2018
Variable rate issues		
New Hampshire Health and Education facilities Authority (NHHEFA) revenue bonds		
Series 2018A, principal maturing in varying annual amounts, through August 2037 (1)	$ 83,355	$ 83,355
Fixed rate issues		
New Hampshire Health and Education facilities Authority revenue bonds		
Series 2018B, principal maturing in varying annual amounts, through August 2048 (1)	303,102	303,102
Series 2017A, principal maturing in varying annual amounts, through August 2040 (2)	122,435	122,435
Series 2017B, principal maturing in varying annual amounts, through August 2031 (2)	109,800	109,800
Series 2014A, principal maturing in varying annual amounts, through August 2022 (3)	26,960	26,960
Series 2018C, principal maturing in varying annual amounts, through August 2030 (4)	25,865	-
Series 2012, principal maturing in varying annual amounts, through July 2039 (5)	25,145	25,955
Series 2014B, principal maturing in varying annual amounts, through August 2033 (3)	14,530	14,530
Series 2016B, principal maturing in varying annual amounts, through August 2045 (6)	10,970	10,970
Total variable and fixed rate debt	$ 722,162	$ 697,107

A summary of long-term debt at June 30, 2019 and 2018 is as follows:

(in thousands of dollars)	2019	2018
Other		
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)*	$ -	$ 15,498
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	445	646
Note payable to a financial institution with entire principal due June 2029 that is collateralized by land and building. The note payable is interest free*	323	380
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,629	2,697
Obligations under capital leases	17,526	18,965
Total other debt	20,923	38,186
Total variable and fixed rate debt	722,162	697,107
Total long-term debt	743,085	735,293
Less: Original issue discounts and premiums, net	(25,542)	(26,862)
Bond issuance costs, net	5,533	5,716
Current portion	10,914	3,464
	$ 752,180	$ 752,975

* Represents nonobligated group bonds

Aggregate annual principal payments required under revenue bond agreements and capital lease obligations for the next five years ending June 30 and thereafter are as follows:

(in thousands of dollars)	
2020	$ 10,914
2021	10,693
2022	10,843
2023	7,980
2024	3,016
Thereafter	699,639
	$ 743,085

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds
MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of D-HH, MHMH, DHC, Cheshire, NLH, MAHHC, and, effective August 15, 2018, APD. D-HH is designated as the obligated group agent.

Revenue Bonds issued by members of the DHOG are administered through notes registered in the name of the Bond Trustee and in accordance with the terms of a Master Trust Indenture. The Master Trust Indenture contains provisions permitting the addition, withdrawal, or consolidation of members of the DHOG under certain conditions. The notes constitute a joint and several obligation of the members of the DHOG (and any other future members of the DHOG) and are equally and ratably collateralized by a pledge of the members' gross receipts. The DHOG is also subject to certain annual covenants under the Master Trust Indenture, the most restrictive is the Annual Debt Service Coverage Ratio (1.10x).

(1) Series 2018A and Series 2018B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018A and Series 2018B in February 2018. The Series 2018A Revenue Bonds were primarily used to refund a portion of Series 2015A and Series 2016A. The Series 2018B were primarily used to refund a portion of Series 2015A and Series 2016A, Revolving Line of Credit, Series 2012 Bank Loan and the Series 2015A and Series 2016A Swap terminations. A loss on the extinguishment of debt of approximately $578,000 was recognized in nonoperating gains (losses) on the statement of operations and changes in net assets, as a result of the refinancing. The interest on the Series 2018A Revenue Bonds is variable with a current interest rate of 5.00% and matures in variable amounts through 2037. The interest on the Series 2018B Revenue Bonds is fixed with an interest rate of 4.18% and matures in variable amounts through 2048.

(2) Series 2017A and Series 2017B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2017A and Series 2017B in December, 2017. The Series 2017A Revenue Bonds were primarily used to refund Series 2009 and Series 2010 and the Series 2017B Revenue Bonds were used to refund Series 2012A and Series 2012B. The interest on the Series 2017A Revenue Bonds is fixed with an interest rate of 5.00% and matures in variable amounts through 2040. The interest on the Series 2017B Revenue Bonds is fixed with an interest rate of 2.54% and matures in variable amounts through 2031.

(3) Series 2014A and Series 2014B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B in August 2014. The proceeds from the Series 2014A and 2014B Revenue Bonds were used to partially refund the Series 2009 Revenue Bonds and to cover cost of issuance. Interest on the 2014A Revenue Bonds is fixed with an interest rate of 2.63% and matures at various dates through 2022. Interest on the Series 2014B Revenue Bonds is fixed with an interest rate of 4.00% and matures at various dates through 2033.

(4) Series 2018C Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2018C in August, 2018. The Series 2018C Revenue Bonds were used primarily to refinance the Series 2010 Revenue Bonds. The interest on the series 2018C Revenue Bonds is fixed with an interest rate of 3.22% and matures in variable amounts through 2030.

(5) Series 2012 Revenue Bonds

The NHHEFA issued $29,650,000 of tax-exempt Revenue Bonds, Series 2012. The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%), and matures in variable amounts through 2039.

(6) Series 2016B Revenue Bonds

The DHOG issued NHHEFA Revenue Bonds, Series 2016B in July 2016 through a private placement with a financial institution. The Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2045.

Outstanding joint and several indebtedness of the DHOG at June 30, 2019 and 2018 approximates $722,162,000 and $697,107,000, respectively.

Non Obligated Group Bonds
(1) Series 2010 Revenue Bonds

The Business Finance Authority (BFA) of the State of NH issued Revenue Bonds, Series 2010. Interest is based on an annual percentage rate equal to the sum of (a) 69% of the 1-Month LIBOR rate plus (b) 1.8975/5. The Health System redeemed these bonds in August 2018.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $631,000 and $1,872,000 at June 30, 2019 and 2018, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets (Note 5). The debt service reserves are mainly comprised of escrowed funds held for future principal and interest payments.

For the years ended June 30, 2019 and 2018 interest expense on the Health System's long term debt is reflected in the accompanying consolidated statements of operations and changes in net assets as operating expense of approximately $25,514,000 and $18,822,000 and other nonoperating losses of $3,784,000 and $2,793,000, respectively.

Swap Agreements
The Health System is subject to market risks such as changes in interest rates that arise from normal business operation. The Health System regularly assesses these risks and has established business strategies to provide natural offsets, supplemented by the use of derivative financial instruments to protect against the adverse effect of these and other market risks. The Health System has established clear policies, procedures, and internal controls governing the use of derivatives and does not use them for trading, investment, or other speculative purposes.

As of June 30, 2019 and 2018, there was no liability for interest rate swaps as all remaining swaps were terminated in February 2018. For the year ended June 30, 2018, the Health System recognized a nonoperating loss due to swap termination of $14,247,000 relating to the swap termination. The change in fair value during the year ended June 30, 2018 was a decrease of $4,897,000. For the year ended June 30, 2018 the Health System recognized a nonoperating gain of $145,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

11. Employee Benefits

All eligible employees of the Health System are covered under various defined benefit and/or define contribution plans. In addition, certain members provide postretirement medical and life benefit plans to certain of its active and former employees who meet eligibility requirements. The postretirement medical and life plans are not funded.

All of the defined benefit plans within the Health System have been frozen and therefore there are no remaining participants earning benefits in any of the Health System's defined benefit plans.

The Health System continued to execute the settlement of obligations due to retirees in the defined benefit plans through bulk lump sum offerings or purchases of annuity contracts. The annuity purchases follow guidelines established by the Department of Labor (DOL). The Health System anticipates continued consideration and/or implementation of additional settlements over the next several years.

Defined Benefit Plans
Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Service cost for benefits earned during the year	$ 150	$ 150
Interest cost on projected benefit obligation	47,814	47,190
Expected return on plan assets	(65,270)	(64,561)
Net loss amortization	10,357	10,593
Total net periodic pension expense	$ (6,949)	$ (6,628)

The following assumptions were used to determine net periodic pension expense as of June 30, 2019 and 2018:

	2019	2018
Discount rate	3.90 % – 4.60%	4.00 % – 4.30 %
Rate of increase in compensation	N/A	N/A
Expected long-term rate of return on plan assets	7.50%	7.50 % – 7.75 %

The following table sets forth the funded status and amounts recognized in the Health System's consolidated financial statements for the defined benefit pension plans at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,087,940	$ 1,122,615
Service cost	150	150
Interest cost	47,814	47,190
Benefits paid	(51,263)	(47,550)
Expenses paid	(170)	(172)
Actuarial (gain) loss	93,358	(34,293)
Settlements	(42,306)	-
Benefit obligation at end of year	1,135,523	1,087,940
Change in plan assets		
Fair value of plan assets at beginning of year	884,983	878,701
Actual return on plan assets	85,842	33,291
Benefits paid	(51,263)	(47,550)
Expenses paid	(170)	(172)
Employer contributions	20,631	20,713
Settlements	(42,306)	-
Fair value of plan assets at end of year	897,717	884,983
Funded status of the plans	(237,806)	(202,957)
Less: Current portion of liability for pension	(46)	(45)
Long term portion of liability for pension	(237,760)	(202,912)
Liability for pension	$ (237,760)	$ (202,912)

As of June 30, 2019 and 2018 the liability, for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in net assets without donor restrictions include approximately $478,394,000 and $418,971,000 of net actuarial loss as of June 30, 2019 and 2018, respectively.

The estimated amounts to be amortized from net assets without donor restrictions into net periodic pension expense in fiscal year 2020 for net actuarial losses is $12,032,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,135,770,000 and $1,087,991,000 at June 30, 2019 and 2018, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2019 and 2018:

	2019	2018
Discount rate	4.20% - 4.50%	4.20 % – 4.50 %
Rate of increase in compensation	N/A	N/A

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of both June 30, 2019 and 2018, it is expected that the LDI strategy will hedge approximately 60% of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

The range of target allocation percentages and the target allocations for the various investments are as follows:

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5%	3 %
U.S. government securities	0–10	5
Domestic debt securities	20–58	38
Global debt securities	6–26	8
Domestic equities	5–35	19
International equities	5–15	11
Emerging market equities	3–13	5
Real estate investment trust funds	0–5	0
Private equity funds	0–5	0
Hedge funds	5–18	11

To the extent an asset class falls outside of its target range on a quarterly basis, the Health System shall determine appropriate steps, as it deems necessary, to rebalance the asset class.

The Boards of Trustees of the Health System, as Plan Sponsors, oversee the design, structure, and prudent professional management of the Health System's Plans' assets, in accordance with Board approved investment policies, roles, responsibilities and authorities and more specifically the following:

- Establishing and modifying asset class targets with Board approved policy ranges,
- Approving the asset class rebalancing procedures,
- Hiring and terminating investment managers, and
- Monitoring performance of the investment managers, custodians and investment consultants.

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 7. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are generally required to consider such investments as Level 2 or 3, even though the underlying securities may not be difficult to value or may be readily marketable.

The following table sets forth the Health System's Plans' investments and deferred compensation plan assets that were accounted for at fair value as of June 30, 2019 and 2018:

	2019					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 166	$ 18,232	$ -	$ 18,398	Daily	1
U.S. government securities	48,580	-	-	48,580	Daily–Monthly	1–15
Domestic debt securities	122,178	273,424	-	395,602	Daily–Monthly	1–15
Global debt securities	428	75,146	-	75,574	Daily–Monthly	1–15
Domestic equities	159,259	18,316	-	177,575	Daily–Monthly	1–10
International equities	17,232	77,146	-	94,378	Daily–Monthly	1–11
Emerging market equities	321	39,902	-	40,223	Daily–Monthly	1–17
REIT funds	357	2,883	-	3,240	Daily–Monthly	1–17
Private equity funds	-	-	21	21	See Note 7	See Note 7
Hedge funds	-	-	44,126	44,126	Quarterly–Annual	60–96
Total investments	$ 348,521	$ 505,049	$ 44,147	$ 897,717		

	2018					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 142	$ 35,817	$ -	$ 35,959	Daily	1
U.S. government securities	46,265	-	-	46,265	Daily–Monthly	1–15
Domestic debt securities	144,131	220,202	-	364,333	Daily–Monthly	1–15
Global debt securities	470	74,676	-	75,146	Daily–Monthly	1–15
Domestic equities	158,634	17,594	-	176,228	Daily–Monthly	1–10
International equities	18,656	80,803	-	99,459	Daily–Monthly	1–11
Emerging market equities	382	39,881	-	40,263	Daily–Monthly	1–17
REIT funds	371	2,686	-	3,057	Daily–Monthly	1–17
Private equity funds	-	-	23	23	See Note 7	See Note 7
Hedge funds	-	-	44,250	44,250	Quarterly–Annual	60–96
Total investments	$ 369,051	$ 471,659	$ 44,273	$ 884,983		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2019 and 2018:

	2019		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 44,250	$ 23	$ 44,273
Net unrealized losses	(124)	(2)	(126)
Balances at end of year	$ 44,126	$ 21	$ 44,147

	2018		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 40,507	$ 96	$ 40,603
Sales	-	(51)	(51)
Net realized losses	-	(51)	(51)
Net unrealized gains	3,743	29	3,772
Balances at end of year	$ 44,250	$ 23	$ 44,273

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2019 and 2018 were approximately $14,617,000 and $14,743,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2019 and 2018.

There were no transfers into and out of Level 1 and 2 measurements due to changes in valuation methodologies during the years ended June 30, 2019 and 2018.

The weighted average asset allocation for the Health System's Plans at June 30, 2019 and 2018 by asset category is as follows:

	2019	2018
Cash and short-term investments	2 %	4 %
U.S. government securities	5	5
Domestic debt securities	44	41
Global debt securities	9	9
Domestic equities	20	20
International equities	11	11
Emerging market equities	4	5
Hedge funds	5	5
	100 %	100 %

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

The Health System is expected to contribute approximately $20,426,000 to the Plans in 2020 however actual contributions may vary from expected amounts.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the years ending June 30 and thereafter:

(in thousands of dollars)

2020	$ 50,743
2021	52,938
2022	55,199
2023	57,562
2024	59,843
2025 – 2028	326,737

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its members, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of approximately $40,537,000 and $38,563,000 in 2019 and 2018, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

Various 403(b) and tax- sheltered annuity plans are available to employees of the Health System. Plan specifications vary by member and plan. No employer contributions were made to any of these plans in 2019 and 2018, respectively.

Postretirement Medical and Life Benefits
The Health System has postretirement medical and life benefit plans covering certain of its active and former employees. The plans generally provide medical or medical and life insurance benefits to certain retired employees who meet eligibility requirements. The plans are not funded.

Net periodic postretirement medical and life benefit (income) cost is comprised of the components listed below for the years ended June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Service cost	$ 384	$ 533
Interest cost	1,842	1,712
Net prior service income	(5,974)	(5,974)
Net loss amortization	10	10
	$ (3,738)	$ (3,719)

The following table sets forth the accumulated postretirement medical and life benefit obligation and amounts recognized in the Health System's consolidated financial statements at June 30, 2019 and 2018:

(in thousands of dollars)	2019	2018
Change in benefit obligation		
Benefit obligation at beginning of year	$ 42,581	$ 42,277
Service cost	384	533
Interest cost	1,842	1,712
Benefits paid	(3,149)	(3,174)
Actuarial loss	5,013	1,233
Employer contributions	-	-
Benefit obligation at end of year	46,671	42,581
Funded status of the plans	$ (46,671)	$ (42,581)
Current portion of liability for postretirement medical and life benefits	$ (3,422)	$ (3,266)
Long term portion of liability for postretirement medical and life benefits	(43,249)	(39,315)
Liability for postretirement medical and life benefits	$ (46,671)	$ (42,581)

As of June 30, 2019 and 2018, the liability for postretirement medical and life benefits is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic postretirement medical and life benefit income and included in the change in net assets without donor restrictions are as follows:

(in thousands of dollars)	2019	2018
Net prior service income	$ (9,556)	$ (15,530)
Net actuarial loss	8,386	3,336
	$ (1,170)	$ (12,194)

The estimated amounts that will be amortized from net assets without donor restrictions into net periodic postretirement income in fiscal year 2020 for net prior service cost is $5,974,000.

The following future benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2020 and thereafter:

(in thousands of dollars)	
2020	$ 3,468
2021	3,436
2022	3,394
2023	3,802
2024	3,811
2025-2028	17,253

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 3.70% in 2019 and an assumed healthcare cost trend rate of 6.50%, trending down to 5.00% in 2024 and thereafter. Increasing the assumed healthcare cost trend rates by one percentage point in each year would increase the accumulated postretirement medical benefit obligation as of June 30, 2019 and 2018 by $1,601,000 and $1,088,000 and the net periodic postretirement medical benefit cost for the years then ended by $77,000 and $81,000, respectively. Decreasing the assumed healthcare cost trend rates by one percentage point in each year would decrease the accumulated postretirement medical benefit obligation as of June 30, 2019 and 2018 by $1,452,000 and $996,000 and the net periodic postretirement medical benefit cost for the years then ended by $71,000 and $72,000, respectively.

12. Professional and General Liability Insurance Coverage

Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic, along with Dartmouth College, Cheshire Medical Center, The New London Hospital Association, Mt. Ascutney Hospital and Health Center, and the Visiting Nurse and Hospice for VT and NH are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a VT captive insurance company. Effective November 1, 2018 Alice Peck Day Memorial Hospital is provided professional and general liability insurance coverage through RRG. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock Clinic, and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

Selected financial data of HAC and RRG, taken from the latest available financial statements at June 30, 2019 and 2018, are summarized as follows:

	2019		
(in thousands of dollars)	**HAC**	**RRG**	**Total**
Assets	$ 75,867	$ 2,201	$ 78,068
Shareholders' equity	13,620	50	13,670

	2018		
(in thousands of dollars)	**HAC**	**RRG**	**Total**
Assets	$ 72,753	$ 2,068	$ 74,821
Shareholders' equity	13,620	50	13,670

13. Commitments and Contingencies

Litigation
The Health System is involved in various malpractice claims and legal proceedings of a nature considered normal to its business. The claims are in various stages and some may ultimately be brought to trial. While it is not feasible to predict or determine the outcome of any of these claims, it is the opinion of management that the final outcome of these claims will not have a material effect on the consolidated financial position of the Health System.

Operating Leases and Other Commitments
The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $12,707,000 and $14,096,000 for the years ended June 30, 2019 and 2018, respectively.

Minimum future lease payments under noncancelable operating leases at June 30, 2019 were as follows:

(in thousands of dollars)	
2020	$ 11,342
2021	10,469
2022	7,488
2023	6,303
2024	4,127
Thereafter	5,752
	$ 45,481

Lines of Credit

The Health System has entered into Loan Agreements with financial institutions establishing access to revolving loans ranging from $2,000,000 up to $30,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 27, 2020. There was no outstanding balance under the lines of credit as of June 30, 2019 and 2018. Interest expense was approximately $95,000 and $232,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses are presented by functional classification in accordance with the overall service missions of the Health System. Each functional classification displays all expenses related to the underlying operations by natural classification. Salaries, employee benefits, medical supplies and medications, and purchased services and other expenses are generally considered variable and are allocated to the mission that best aligns to the type of service provided. Medicaid enhancement tax is allocated to program services. Interest expense is allocated based on usage of debt-financed space. Depreciation and amortization is allocated based on square footage and specific identification of equipment used by department.

Operating expenses of the Health System by functional and natural basis are as follows for the year ended June 30, 2019:

	2019			
(in thousands of dollars)	Program Services	Management and General	Fundraising	Total
Operating expenses				
Salaries	$ 922,902	$ 138,123	$ 1,526	$ 1,062,551
Employee benefits	178,983	72,289	319	251,591
Medical supplies and medications	406,782	1,093	-	407,875
Purchased services and other	212,209	108,783	2,443	323,435
Medicaid enhancement tax	70,061	-	-	70,061
Depreciation and amortization	37,528	50,785	101	88,414
Interest	3,360	22,135	19	25,514
Total operating expenses	$ 1,831,825	$ 393,208	$ 4,408	$ 2,229,441

Operating expenses of the Health System by functional classification are as follows for the year ended June 30, 2018:

(in thousands of dollars)

Program services	$ 1,715,760
Management and general	303,527
Fundraising	2,354
	$ 2,021,641

15. Liquidity

The Health System is substantially supported by cash generated from operations. In addition, the Health System holds financial assets for specific purposes which are limited as to use. Thus, certain financial assets reported on the accompanying consolidated balance sheet may not be available for general expenditure within one year of the balance sheet date.

The Health System's financial assets available at June 30, 2019 to meet cash needs for general expenditures within one year of June 30, 2019 are as follows:

(in thousands of dollars)

Cash and cash equivalents	$ 143,587
Patient accounts receivable	221,125
Assets limited as to use	876,249
Other investments for restricted activities	134,119
Total financial assets	1,375,080
Less: Those unavailable for general expenditure within one year:	
Investments held by captive insurance companies	66,082
Investments for restricted activities	134,119
Other investments with liquidity horizons greater than one year	97,063
Total financial assets available within one year	$ 1,077,816

For the years ending June 30, 2019 and June 30, 2018, the Health System generated positive cash flow from operations of approximately $161,853,000 and $136,031,000, respectively. In addition, the Health System's liquidity management plan includes investing excess daily cash in intermediate or long term investments based on anticipated liquidity needs. The Health System has an available line of credit of up to $30,000,000 which it can draw upon as needed to meet its liquidity needs. See Note 13 for further details on the line of credit.

16. Subsequent Events

The Health System has assessed the impact of subsequent events through November 26, 2019, the date the audited consolidated financial statements were issued, and has concluded that there were no such events that require adjustment to the audited consolidated financial statements or disclosure in the notes to the audited consolidated financial statements other than as noted below.

Effective September 30, 2019, the Boards of Trustees of D-HH, GraniteOne Health, Catholic Medical Center Health Services, and their respective member organizations approved a Combination Agreement to combine their healthcare systems. If regulatory approval of the

transaction is obtained, the name of the new system will be Dartmouth-Hitchcock Health GraniteOne.

The GraniteOne Health system is comprised of Catholic Medical Center (CMC), a community hospital located in Manchester NH, Huggins Hospital located in Wolfeboro NH, and Monadnock Community Hospital located in Peterborough NH. Both Huggins Hospital and Monadnock Community Hospital are designated as Critical Access Hospitals. GraniteOne is a non-profit, community based health care system.

On September 13, 2019, the Board of Trustees of D-HH approved the issuance of up to $100,000,000 par of new debt. On October 17, 2019, D-HH closed on the direct placement tax-exempt borrowing of $99,165,000 on behalf of the DHOG acting through the New Hampshire Health and Education Facilities Authority and issued its DHOG Issue, Series 2019A Bonds.

On January 29, 2020, D-HH closed on a tax-exempt borrowing of $125,000,000 on behalf of the DHOG acting through the New Hampshire Health and Education Facilities Authority and issued its DHOG Issue, Series 2020A Bonds.

17. Subsequent Events - Unaudited

Subsequent to the issuance of the audited financial statements on November 26, 2019, the novel strain of coronavirus emerged and in January 2020 the World Health Organization has declared the novel coronavirus a Public Health Emergency of International Concern. Beginning in March 2020, the State of New Hampshire and Vermont have adopted various measures to address the spread of this pandemic, including supporting social distancing, requests to stay home unless necessary (i.e., groceries or medications) and work from home recommendations. Such restrictions and the perception that such orders or restrictions could occur, have resulted in business closures, work stoppages, slowdowns and delays, work-from-home policies, travel restrictions and cancellation of events, including the rescheduling of elective or non-critical procedures (which management believes is temporary and such procedures will be performed at a later date) and redeployment of resources to address the novel coronavirus needs, among other effects. The outbreak has also negatively impacted the financial markets and has and may continue to materially affect the returns on and value of our investments. While we expect that the novel coronavirus may negatively impact our 2020 results, we believe we have sufficient liquidity to meet our operating and financing needs; however, given the difficulty in predicting the ultimate duration and severity of the impact of the novel coronavirus on our organization, the economy and the financial markets, the ultimate impact may be material.

Consolidating Supplemental Information – Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 42,456	$ 47,465	$ 9,411	$ 7,066	$ 10,462	$ 8,372	$ -	$ 125,232	$ 18,355	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	8,960	5,010	-	218,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,563	2,401	5,567	1,423	(74,083)	97,083	1,421	(3,009)	95,495
Total current assets	56,634	367,437	33,854	16,746	24,989	14,805	(74,083)	440,382	22,834	(3,009)	460,207
Assets limited as to use	92,602	688,485	18,759	12,684	12,427	11,619	-	836,576	39,673	-	876,249
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	91,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,946	17,797	-	590,134	31,122	-	621,256
Other assets	24,864	108,208	1,279	15,019	6,042	4,388	(10,970)	148,830	(3,013)	(21,346)	124,471
Total assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 954	$ 547	$ 262	$ -	$ 10,819	$ 95	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,884	15,620	6,299	3,878	2,776	(74,083)	109,873	6,953	(3,009)	113,817
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,767	1,641	-	128,408
Estimated third-party settlements	-	26,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
Total current liabilities	55,499	248,622	22,404	12,237	17,589	10,229	(74,083)	292,497	8,689	(3,009)	298,177
Notes payable, related party	-	526,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	643	11,465	(10,970)	749,322	2,858	-	752,180
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	98,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
Total liabilities	698,756	1,241,058	58,713	48,382	48,239	26,254	(639,289)	1,482,113	34,805	(3,009)	1,513,909
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	28,832	356,880	63,051	27,653	35,518	21,242	-	533,176	48,063	(21,306)	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,282	(40)	142,460
Total net assets	28,850	447,983	69,296	28,449	40,138	28,678	-	643,394	80,345	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 42,456	$ 48,052	$ 11,952	$ 11,120	$ 8,549	$ 15,772	$ 5,686	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
Total current assets	56,634	368,822	37,292	25,647	15,010	24,730	9,164	(77,092)	460,207
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Other assets	24,864	108,366	7,388	5,476	1,931	8,688	74	(32,316)	124,471
Total assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 547	$ 288	$ 954	$ 69	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
Total current liabilities	55,499	249,179	26,140	17,590	10,379	13,140	3,342	(77,092)	298,177
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
Total liabilities	698,756	1,241,615	62,460	48,240	26,702	72,492	5,942	(642,298)	1,513,909
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	28,832	379,498	65,873	36,087	21,300	22,327	27,322	(21,306)	559,933
Net assets with donor restrictions	18	99,184	29,561	4,619	7,435	1,653	30	(40)	142,460
Total net assets	28,850	478,682	95,434	40,706	28,735	23,980	27,352	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets										
Current assets										
Cash and cash equivalents	$ 134,634	$ 22,544	$ 6,688	$ 9,419	$ 6,604	$ -	$ 179,889	$ 20,280	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,964	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,598	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
Assets limited as to use	8	616,929	17,438	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	554,771	-	-	-	-	(554,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,981	6,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	66,759	42,438	17,356	-	569,743	37,578	-	607,321
Other assets	24,863	101,078	1,370	5,906	4,280	(10,970)	126,527	3,604	(21,346)	108,785
Total assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 187	$ -	$ 2,600	$ 864	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,995	82,061	20,107	6,705	3,029	(72,361)	94,536	6,094	(4,877)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	-	38,693	2,448	-	41,141
Total current liabilities	57,997	217,299	26,647	19,419	8,637	(72,361)	257,638	16,484	(4,877)	269,245
Notes payable, related party	-	527,346	-	27,425	-	(554,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,616	465	155	240	-	55,476	40	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,788	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
Commitments and contingencies										
Net assets										
Net assets without donor restrictions	23,759	334,882	61,828	32,897	19,812	-	473,178	72,230	(21,306)	524,102
Net assets with donor restrictions	-	86,898	4,964	4,640	7,400	-	103,902	33,971	(40)	137,833
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2018

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 134,634	$ 23,094	$ 8,621	$ 9,982	$ 6,654	$ 12,144	$ 5,040	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,109	7,996	3,657	-	219,228
Prepaid expenses and other current assets	11,964	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,598	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,438	12,821	11,862	9,612	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,607	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,863	101,235	7,526	5,333	1,886	130	128	(32,316)	108,785
Total assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 245	$ 739	$ 67	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,613	20,052	6,714	3,092	3,596	1,929	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,593	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,616	465	155	241	-	39	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	28	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(642,979)	1,408,090
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	23,759	356,518	65,069	33,383	19,764	21,031	25,884	(21,306)	524,102
Net assets with donor restrictions	-	95,212	29,956	4,640	7,401	634	30	(40)	137,833
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,580,552	$ 220,255	$ 69,794	$ 60,166	$ 46,029	$ -	$ 1,976,796	$ 22,527	$ -	$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
Total operating revenue and other support	26,508	1,888,011	224,749	71,679	64,604	54,244	(68,176)	2,261,619	37,813	(289)	2,299,143
Operating expenses											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	208,346	24,225	6,454	5,434	6,966	(3,763)	247,662	3,642	287	251,591
Medical supplies and medications	-	354,201	34,331	8,634	6,298	3,032	-	406,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,622)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,061	-	-	70,061
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,360	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,818,846	218,350	74,229	63,107	54,826	(70,471)	2,190,944	38,726	(229)	2,229,441
Operating (loss) margin	(5,549)	69,165	6,399	(2,550)	1,497	(582)	2,295	70,675	(913)	(60)	69,702
Nonoperating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	623	(198)	38,077	1,975	-	40,052
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	60	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-	-	-
Total non-operating gains (losses), net	145	33,779	40	412	594	902	(2,295)	33,577	2,766	60	36,403
(Deficiency) excess of revenue over expenses	(5,404)	102,944	6,439	(2,138)	2,091	320	-	104,252	1,853	-	106,105
Net assets without donor restrictions											
Net assets released from restrictions	-	419	565	-	402	318	-	1,704	65	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 21,998	$ 1,223	$ 6,622	$ 2,621	$ 1,430	$ -	$ 38,967	$ (3,136)	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets without Donor Restrictions
Year Ended June 30, 2019

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,580,552	$ 220,254	$ 60,166	$ 46,029	$ 69,794	$ 22,528	$ -	$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	182	-	-	14,105
Total operating revenue and other support	26,509	1,891,806	224,890	64,603	55,825	80,907	23,068	(68,465)	2,299,143
Operating expenses									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	208,346	24,235	5,434	7,133	7,218	2,701	(3,476)	251,591
Medical supplies and medications	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,366	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
Total operating expenses	32,058	1,822,841	218,852	62,974	56,340	83,653	23,423	(70,700)	2,229,441
Operating (loss) margin	(5,549)	68,965	6,038	1,629	(515)	(2,746)	(355)	2,235	69,702
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	785	645	469	983	(198)	40,052
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-
Total nonoperating gains (losses), net	145	34,896	(42)	545	933	413	1,748	(2,235)	36,403
(Deficiency) excess of revenue over expenses	(5,404)	103,861	5,996	2,174	418	(2,333)	1,393	-	106,105
Net assets without donor restrictions									
Net assets released from restrictions	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	118	3,629	45	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 22,980	$ 804	$ 2,704	$ 1,536	$ 1,296	$ 1,438	$ -	$ 35,831

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended June 30, 2018

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support										
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ -	$ 1,804,550	$ 94,545	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	-	45,319	2,048	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	-	1,759,231	92,497	-	1,851,728
Contracted revenue	(2,305)	97,291	-	-	2,169	(42,870)	54,285	716	(32)	54,969
Other operating revenue	9,799	134,461	3,365	4,169	1,814	(10,554)	143,054	6,978	(1,086)	148,946
Net assets released from restrictions	658	11,605	620	52	44	-	12,979	482	-	13,461
Total operating revenue and other support	8,152	1,687,313	209,754	63,153	54,601	(53,424)	1,969,549	100,673	(1,118)	2,069,104
Operating expenses										
Salaries	-	806,344	105,607	30,360	24,854	(21,542)	945,623	42,035	1,605	989,263
Employee benefits	-	181,833	28,343	7,252	7,000	(5,385)	219,043	10,221	419	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,055	-	329,836	10,195	-	340,031
Purchased services and other	8,509	215,073	33,065	13,587	13,960	(19,394)	264,800	29,390	(2,818)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,744	-	65,517	2,175	-	67,692
Depreciation and amortization	23	66,073	10,217	3,934	2,030	-	82,277	2,501	-	84,778
Interest	8,684	15,772	1,004	981	224	(8,882)	17,783	1,039	-	18,822
Total operating expenses	17,216	1,627,466	217,599	64,934	52,867	(55,203)	1,924,879	97,556	(794)	2,021,641
Operating margin (loss)	(9,064)	59,847	(7,845)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,463
Non-operating gains (losses)										
Investment income (losses), net	(26)	33,628	1,408	1,151	858	(198)	36,821	3,566	-	40,387
Other (losses) income, net	(1,364)	(2,599)	-	1,276	266	(1,581)	(4,002)	733	361	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	2,873	1,408	2,122	1,124	(1,779)	4,358	4,299	361	9,018
(Deficiency) excess of revenue over expenses	(10,454)	62,720	(6,437)	341	2,858	-	49,028	7,416	37	56,481
Net assets without donor restrictions										
Net assets released from restrictions	-	16,038	-	4	252	-	16,294	19	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	58	(58)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	4,190	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	14,102	-	-	14,102
Increase in net assets without donor restrictions	$ 7,337	$ 75,995	$ 3,578	$ 393	$ 4,565	$ -	$ 91,868	$ 7,308	$ (21)	$ 99,155

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Net Assets Without Donor Restrictions
Year Ended June 30, 2018

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ 71,458	$ 23,087	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	1,680	368	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,305)	98,007	-	-	2,169	-	-	(42,902)	54,969
Other operating revenue	9,799	137,242	4,061	4,166	3,168	1,697	453	(11,640)	148,946
Net assets released from restrictions	658	11,984	620	52	44	103	-	-	13,461
Total operating revenue and other support	8,152	1,691,189	210,450	63,150	55,955	71,578	23,172	(54,542)	2,069,104
Operating expenses									
Salaries	-	806,344	105,607	30,360	25,592	29,215	12,082	(19,937)	989,263
Employee benefits	-	181,833	28,343	7,252	7,162	7,406	2,653	(4,966)	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,057	8,484	1,709	-	340,031
Purchased services and other	8,512	218,690	33,431	13,432	14,354	19,220	5,945	(22,212)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,743	2,176	-	-	67,692
Depreciation and amortization	23	66,073	10,357	3,939	2,145	1,831	410	-	84,778
Interest	8,684	15,772	1,004	981	223	975	65	(8,882)	18,822
Total operating expenses	17,219	1,631,083	218,105	64,784	54,276	69,307	22,864	(55,997)	2,021,641
Operating (loss) margin	(9,067)	60,106	(7,655)	(1,634)	1,679	2,271	308	1,455	47,463
Nonoperating gains (losses)									
Investment income (losses), net	(26)	35,177	1,954	1,097	787	203	1,393	(198)	40,387
Other (losses) income, net	(1,364)	(2,599)	(3)	1,276	273	(223)	952	(1,220)	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	4,422	1,951	2,068	1,060	(20)	2,345	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,528	(5,704)	434	2,739	2,251	2,653	37	56,481
Net assets without donor restrictions									
Net assets released from restrictions	-	16,058	-	4	251	-	-	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(185)	-	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase (decrease) in net assets without donor restrictions	$ 7,392	$ 77,823	$ 4,311	$ 486	$ 4,445	$ 2,066	$ 2,653	$ (21)	$ 99,155

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Supplemental Consolidating Information
June 30, 2019 and 2018

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in net assets without donor restrictions of D-HH and its subsidiaries. All intercompany accounts and transactions between D-HH and its subsidiaries have been eliminated. The consolidating information presented is prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America consistent with the consolidated financial statements. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements and is not required as part of the basic financial statements.

Schedule of Expenditures of Federal Awards

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Federal Program						
Research and Development Cluster						
Department of Defense						
National Guard Military Operations and Maintenance (O&M) Projects	12.401	W81XWH1820078	Direct		$ 234,830	$ -
Military Medical Research and Development	12.420	W81XWH1810712	Direct		131,525	-
Military Medical Research and Development	12.420	R1143	Pass-Through	Trustees of Dartmouth College	2,055	-
					133,580	-
Department of Defense	12.RD	80232	Pass-Through	Creare, Inc.	46,275	-
					414,485	-
Environmental Protection Agency						
Science To Achieve Results (STAR) Research Program	66.509	31220SUB52965	Pass-Through	University of Vermont	1,031	-
					1,031	-
Department of Health and Human Services						
Innovations in Applied Public Health Research	93.061	1 R01 TS000288	Direct		84,957	8,367
Environmental Health	93.113	6K23ES025781-06	Direct		111,125	-
Environmental Health	93.113	R1118	Pass-Through	Trustees of Dartmouth College	5,087	-
					116,212	-
NIEHS Superfund Hazardous Substances	93.143	R1099	Pass-Through	Trustees of Dartmouth College	6,457	-
Health Program for Toxic Substances and Disease Registry	93.161	AWD00010523	Direct		61,180	-
Research Related to Deafness and Communication Disorders	93.173	6R21DC015133-03	Direct		119,896	61,908
National Research Service Award in Primary Care Medicine	93.186	T32HP32520	Direct		309,112	-
Research and Training in Complementary and Integrative Health	93.213	R1112	Pass-Through	Trustees of Dartmouth College	21,197	-
Research and Training in Complementary and Integrative Health	93.213	R1187	Pass-Through	Trustees of Dartmouth College	446	-
Research and Training in Complementary and Integrative Health	93.213	12272	Pass-Through	Palmer College of Chiropractic	30,748	-
Research and Training in Complementary and Integrative Health	93.213	Not Provided	Pass-Through	Southern California University of Health	12,030	-
					64,421	-
Research on Healthcare Costs, Quality and Outcomes	93.226	5P30HS024403	Direct		641,114	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1128	Pass-Through	Trustees of Dartmouth College	6,003	-
Research on Healthcare Costs, Quality and Outcomes	93.226	R1146	Pass-Through	Trustees of Dartmouth College	4,696	-
					651,813	-
Mental Health Research Grants	93.242	1K08MH117347-01A1	Direct		54,211	-
Mental Health Research Grants	93.242	6K23MH116367-02	Direct		109,228	-
Mental Health Research Grants	93.242	6R01MH110965	Direct		220,078	84,823
Mental Health Research Grants	93.242	6T32MH073553-15	Direct		130,340	-
Mental Health Research Grants	93.242	6R25MH068502-17	Direct		157,599	-
Mental Health Research Grants	93.242	6R01MH107625-05	Direct		200,605	27,964
Mental Health Research Grants	93.242	R1082	Pass-Through	Trustees of Dartmouth College	11,740	-
Mental Health Research Grants	93.242	R1144	Pass-Through	Trustees of Dartmouth College	5,897	-
Mental Health Research Grants	93.242	R1156	Pass-Through	Trustees of Dartmouth College	4,721	-
					894,817	112,787

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Drug Abuse and Addiction Research Programs	93.279	6R01DA034699-05	Direct		390,647	90,985
Drug Abuse and Addiction Research Programs	93.279	6R21DA044501-03	Direct		118,741	-
Drug Abuse and Addiction Research Programs	93.279	6R01DA041416-04	Direct		135,687	62,277
Drug Abuse and Addiction Research Programs	93.279	R1105	Pass-Through	Trustees of Dartmouth College	11,957	-
Drug Abuse and Addiction Research Programs	93.279	R1104	Pass-Through	Trustees of Dartmouth College	4,109	-
Drug Abuse and Addiction Research Programs	93.279	R1192	Pass-Through	Trustees of Dartmouth College	5,059	-
					666,200	153,262
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6K23EB026507-02	Direct		98,499	9,582
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	6R21EB021456-03	Direct		23,293	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	R1103	Pass-Through	Trustees of Dartmouth College	16,635	-
Discovery and Applied Research for Technological Innovations to Improve Human Health	93.286	5R21EB024771-02	Pass-Through	Trustees of Dartmouth College	5,938	-
					144,365	9,582
National Center for Advancing Translational Sciences	93.350	R1113	Pass-Through	Trustees of Dartmouth College	342,790	-
21st Century Cures Act - Beau Biden Cancer Moonshot	93.353	1204501	Pass-Through	Dana Farber Cancer Institute	156,421	-
Cancer Cause and Prevention Research	93.393	1R01CA225792	Direct		54,351	-
Cancer Cause and Prevention Research	93.393	R21CA227776A	Direct		28,640	-
Cancer Cause and Prevention Research	93.393	R01CA229197	Direct		65,701	-
Cancer Cause and Prevention Research	93.393	R1127	Pass-Through	Trustees of Dartmouth College	6,035	-
Cancer Cause and Prevention Research	93.393	R1097	Pass-Through	Trustees of Dartmouth College	5,870	-
Cancer Cause and Prevention Research	93.393	R1109	Pass-Through	Trustees of Dartmouth College	1,984	-
Cancer Cause and Prevention Research	93.393	DHMCCA222648	Pass-Through	The Pennsylvania State University	3,173	-
Cancer Cause and Prevention Research	93.393	R44CA210810	Pass-Through	Cairn Surgical, LLC	38,241	-
					203,995	-
Cancer Detection and Diagnosis Research	93.394	4R00CA190890-03	Direct		1,717	-
Cancer Detection and Diagnosis Research	93.394	6R37CA212187-03	Direct		106,110	2,907
Cancer Detection and Diagnosis Research	93.394	6R03CA219445-03	Direct		18,880	-
Cancer Detection and Diagnosis Research	93.394	R1079	Pass-Through	Trustees of Dartmouth College	23,031	-
Cancer Detection and Diagnosis Research	93.394	R1080	Pass-Through	Trustees of Dartmouth College	23,031	-
Cancer Detection and Diagnosis Research	93.394	R1086	Pass-Through	Trustees of Dartmouth College	6,772	-
Cancer Detection and Diagnosis Research	93.394	R1096	Pass-Through	Trustees of Dartmouth College	1,174	-
Cancer Detection and Diagnosis Research	93.394	R1124	Pass-Through	Trustees of Dartmouth College	83,174	-
					263,889	2,907
Cancer Treatment Research	93.395	1UG1CA233323-01	Direct		14,675	-
Cancer Treatment Research	93.395	6U10CA180854-06	Direct		27,790	-
Cancer Treatment Research	93.395	DAC-194321	Pass-Through	Mayo Clinic	36,708	-

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Cancer Treatment Research	93.395	R1087	Pass-Through	Trustees of Dartmouth College	2,630	-
Cancer Treatment Research	93.395	110408	Pass-Through	Brigham and Women's Hospital	20,430	-
					102,233	-
Cancer Centers Support Grants	93.397	R1126	Pass-Through	Trustees of Dartmouth College	95,624	-
Cardiovascular Diseases Research	93.837	1UM1HL147371-01	Direct		11,774	-
Cardiovascular Diseases Research	93.837	7K23HL142835-02	Direct		65,544	-
					77,318	-
Lung Diseases Research	93.838	6R01HL122372-05	Direct		205,920	8,664
Arthritis, Musculoskeletal and Skin Diseases Research	93.846	6T32AR049710-16	Direct		73,049	-
Diabetes, Digestive, and Kidney Diseases Extramural Research	93.847	R1098	Pass-Through	Trustees of Dartmouth College	70,736	704
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	6R01NS052274-11	Direct		50,412	-
Extramural Research Programs in the Neurosciences and Neurological Disorders	93.853	16-210950-04	Direct		18,016	-
					68,428	-
Allergy and Infectious Diseases Research	93.855	R1081	Pass-Through	Trustees of Dartmouth College	3,787	-
Allergy and Infectious Diseases Research	93.855	RES513934	Pass-Through	Case Western Reserve University	4,170	-
Allergy and Infectious Diseases Research	93.855	R1155	Pass-Through	Trustees of Dartmouth College	14,582	-
					22,539	-
Biomedical Research and Research Training	93.859	R1100	Pass-Through	Trustees of Dartmouth College	14,901	-
Biomedical Research and Research Training	93.859	R1141	Pass-Through	Trustees of Dartmouth College	587	-
Biomedical Research and Research Training	93.859	R1145	Pass-Through	Trustees of Dartmouth College	241	-
					15,729	-
Child Health and Human Development Extramural Research	93.865	5P2CHD086841-04	Direct		127,400	10,132
Child Health and Human Development Extramural Research	93.865	6UG1OD024946-03	Direct		260,914	-
Child Health and Human Development Extramural Research	93.865	6R01HD067270	Direct		314,058	223,885
Child Health and Human Development Extramural Research	93.865	R1119	Pass-Through	Trustees of Dartmouth College	13,264	-
Child Health and Human Development Extramural Research	93.865	51460	Pass-Through	Univ of Arkansas for Medical Sciences	4,696	-
					720,332	234,017
Aging Research	93.866	6K23AG051681-04	Direct		76,377	2,883
Aging Research	93.866	R1102	Pass-Through	Trustees of Dartmouth College	8,285	-
					84,662	2,883
Vision Research	93.867	6R21EY026677-02	Direct		28,751	3,149
Medical Library Assistance	93.879	R1107	Pass-Through	Trustees of Dartmouth College	4,273	-
Medical Library Assistance	93.879	R1190	Pass-Through	Trustees of Dartmouth College	1,244	-
					5,517	-
International Research and Research Training	93.989	R1123	Pass-Through	Trustees of Dartmouth College	5,936	-
International Research and Research Training	93.989	6R25TW007693-09	Pass-Through	Fogarty International Center	96,327	65,097
					102,263	65,097

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
Department of Health and Human Services	93.RD		Pass-Through	Leidos Biomedical Research, Inc.	201,551	-
Total Department of Health and Human Services					5,970,977	663,327
Total Research and Development Cluster					6,386,493	663,327
Medicaid Cluster						
Medical Assistance Program	93.778	SNHH 2-18-19	Pass-Through	Southern New Hampshire Health	131,775	-
Medical Assistance Program	93.778	Not Provided	Pass-Through	NH Dept of Health and Human Services	1,453,796	-
Medical Assistance Program	93.778	RFP-2017-OCOM-01-PHYSI-01	Pass-Through	NH Dept of Health and Human Services	3,106,149	-
Medical Assistance Program	93.778	03420-7235S	Pass-Through	Vermont Department of Health	59,391	
Medical Assistance Program	93.778	03410-2020-19	Pass-Through	Vermont Department of Health	118,786	
Total Medicaid Cluster					4,869,897	-
Highway Safety Cluster						
State and Community Highway Safety	20.600	19-266 Youth Operator	Pass-Through	NH Highway Safety Agency	66,660	-
State and Community Highway Safety	20.600	19-266 BUNH	Pass-Through	NH Highway Safety Agency	76,915	-
State and Community Highway Safety	20.600	19-266 Statewide CPS	Pass-Through	NH Highway Safety Agency	82,202	-
Total Highway Safety Cluster					225,777	-
Other Sponsored Programs						
Department of Justice						
Crime Victim Assistance	16.575	2015-VA-GX0007	Pass-Through	New Hampshire Department of Justice	237,692	-
Improving the Investigation and Prosecution of Child Abuse and the Regional and Local Children's Advocacy Centers	16.758	1-CLAR-NH-SA17	Pass-Through	National Children's Alliance	1,448	-
					239,140	-
Department of Education						
Race to the Top	84.412	03440-34119-16-ELCG24	Pass-Through	Vermont Dept for Children and Families	115,094	-
					115,094	-
Department of Health and Human Services						
Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) Aligned Cooperative Agreements	93.074	Not Provided	Pass-Through	NH Dept of Health and Human Services	69,945	-
Blood Disorder Program: Prevention, Surveillance, and Research	93.080	GENFD0001568485	Pass-Through	Boston Children's Hospital	18,283	-
Maternal and Child Health Federal Consolidated Programs	93.110	6 T73MC323930101	Direct		652,997	591,411
Maternal and Child Health Federal Consolidated Programs	93.110	0253-6545-4609	Pass-Through	Icahn School of Medicine at Mount Sinai	19,548	
					672,545	591,411
Emergency Medical Services for Children	93.127	7 H33MC323950100	Direct		137,067	
Centers for Research and Demonstration for Health Promotion and Disease Prevention	93.135	R1140	Pass-Through	Trustees of Dartmouth College	449,757	-
HIV-Related Training and Technical Assistance	93.145	Not Provided	Pass-Through	University of Massachusetts Med School	3,242	
Coordinated Services and Access to Research for Women, Infants, Children	93.153	H12HA31112	Direct		391,829	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	7H79SM063584-01	Direct		24,313	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	55,361	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	Not Provided	Pass-Through	Vermont Department of Health	227,437	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance	93.243	03420-A19006S	Pass-Through	Vermont Department of Health	126,764	
					433,875	-
Drug Free Communities Support Program Grants	93.276	5H79SP020382	Direct		126,464	-
Department of Health and Human Services	93.628	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	29,838	-

Dartmouth-Hitchcock Health and Subsidiaries
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2019

	CFDA	Award Number/pass-through Identification Number	Funding Source	Pass-Through Entity	Total Expenditures	Amount Passed Through to Subrecipients
University Centers for Excellence in Developmental Disabilities Education, Research, and Service	93.632	19-029	Pass-Through	University of New Hampshire	2,811	-
Adoption Opportunities	93.652	AWD00009303	Direct		32,384	-
Adoption Opportunities	93.652	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	110,524	-
					142,908	-
Preventive Health and Health Services Block Grant funded solely with Prevention and Public Health Funds (PPHF)	93.758	RFP-2018-DPHS-01-REGION-1	Pass-Through	NH Dept of Health and Human Services	343,297	-
University Centers for Excellence in Developmental Disabilities Education, Research, and Service	93.761	90FPSG0019	Direct		134,524	-
Opioid STR	93.788	RFP-2018-BDAS-05-INTEG	Pass-Through	NH Dept of Health and Human Services	954,356	61,208
Opioid STR	93.788	2019-BDAS-05-ACCES-04	Pass-Through	NH Dept of Health and Human Services	161,164	-
Opioid STR	93.788	SS-2019-BDAS-05-ACCES-02	Pass-Through	NH Dept of Health and Human Services	243,747	-
					1,359,267	61,208
Organized Approaches to Increase Colorectal Cancer Screening	93.800	5 NU58DP006086	Direct		912,937	-
Hospital Preparedness Program (HPP) Ebola Preparedness	93.817	03420-6755S	Pass-Through	Vermont Department of Health	2,347	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-6951S	Pass-Through	Vermont Department of Health	99,841	-
Maternal, Infant and Early Childhood Home Visiting Grant	93.870	03420-07623	Pass-Through	Vermont Department of Health	178,907	-
					278,748	-
National Bioterrorism Hospital Preparedness Program	93.889	03420-7272S	Pass-Through	Vermont Department of Health	2,786	-
Rural Health Care Services Outreach, Rural Health Network Develop and Small Health Care Provider Quality Improvement	93.912	6 D06RH31057-02-03	Direct		138,959	-
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918	1 H76HA31654-01-00	Direct		273,666	-
Block Grants for Community Mental Health Services	93.958	9224120	Pass-Through	NH Dept of Health and Human Services	2,498	-
Block Grants for Community Mental Health Services	93.958	RFP-2017-DBH-05-FIRSTE	Pass-Through	NH Dept of Health and Human Services	32,625	-
					35,123	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-49-491510-2990	Pass-Through	NH Dept of Health and Human Services	69,276	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	Not Provided	Pass-Through	Foundation for Healthy Communities	54,356	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	05-95-49-491510-2990	Pass-Through	Foundation for Healthy Communities	1,695	-
Block Grants for Prevention and Treatment of Substance Abuse	93.959	03420-A18033S	Pass-Through	Vermont Department of Health	59,204	-
					184,531	-
PPHF Geriatric Education Centers	93.969	U1QHP32519	Direct		728,055	-
Department of Health and Human Services	93.U01	RFP-2018-DPHS-05-INJUR	Pass-Through	NH Highway Safety Agency	80,107	-
Department of Health and Human Services	93.U02	Not Provided	Pass-Through	NH Dept of Health and Human Services	48,489	-
Department of Health and Human Services	93.U03	Not Provided	Pass-Through	NH Dept of Health and Human Services	56,419	-
Department of Health and Human Services	93.U04	Not Provided	Pass-Through	NH Dept of Health and Human Services	37,009	-
Department of Health and Human Services	93.U05	Not Provided	Pass-Through	NH Dept of Health and Human Services	39,653	-
Department of Health and Human Services	93.U06	Not Provided	Pass-Through	County of Cheshire	213,301	-
					474,978	-
Corporation for National and Community Service AmeriCorps	94.006	17ACHNH0010001	Pass-Through	Volunteer NH	72,297	-
					72,297	-
Total Other Programs					7,774,313	652,619
Total Federal Awards and Expenditures					$ 19,256,480	$ 1,315,946

Dartmouth-Hitchcock Health and Subsidiaries
Notes to Schedule of Expenditures of Federal Awards
June 30, 2019

1. Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") presents the activity of federal award programs administered by Dartmouth-Hitchcock Health and Subsidiaries (the "Health System") as defined in the notes to the consolidated financial statements and is presented on an accrual basis. The purpose of this Schedule is to present a summary of those activities of the Health System for the year ended June 30, 2019 which have been financed by the United States government ("federal awards"). For purposes of this Schedule, federal awards include all federal assistance entered into directly between the Health System and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The information in this Schedule in presented in accordance with the requirements of the Uniform Guidance. Pass-through entity identification numbers and CFDA numbers have been provided where available.

Visiting Nurse and Hospice of NH and VT ("VNH") received a Community Facilities Loan, CFDA #10.766, of which the proceeds were expended in the prior fiscal year. The VNH had an outstanding balance of $2,696,512 as of June 30, 2019. As this loan was related to a project that was completed in the prior audit period and the terms and conditions do not impose continued compliance requirements other than to repay the loan, we have properly excluded the outstanding loan balance from the Schedule.

2. Indirect Expenses

Indirect costs are charged to certain federal grants and contracts at a federally approved predetermined indirect rate, negotiated with the Division of Cost Allocation and therefore we do not use the de minimus 10% rate. The predetermined rate provided for the year ended June 30, 2019 was 29.3%. Indirect costs are included in the reported federal expenditures.

3. Related Party Transactions

The Health System has an affiliation agreement with Dartmouth College dated June 4, 1996 in which the Health System and the Geisel School of Medicine at Dartmouth College affirm their mutual commitment to providing high quality medical care, medical education and medical research at both organizations. Pursuant to this affiliation agreement, certain clinical faculty of the Health System participate in federal research programs administered by Dartmouth College. During the fiscal year ended June 30, 2019, Health System expenditures, which Dartmouth College reimbursed, totaled $3,979,033. Based on the nature of these transactions, the Health System and Dartmouth College do not view these arrangements to be subrecipient transactions but rather view them as Dartmouth College activity. Accordingly, this activity does not appear in the Health System's schedule of expenditures of federal awards for the year ended June 30, 2019.

Part II
Reports on Internal Control and Compliance

Report of Independent Auditors 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*

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

We have audited, 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, the consolidated financial statements of Dartmouth-Hitchcock Health and its subsidiaries (the "Health System"), which comprise the consolidated balance sheet as of June 30, 2019, and the related consolidated statements of operations and changes in net assets and of cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated November 26, 2019, which included an emphasis of a matter paragraph related to the Health System changing the manner in which it accounts for revenue recognition from contracts with customers and the manner in which it presents net assets and reports certain aspects of its financial statements as a not-for-profit entity in 2019 as discussed in note 2 of the consolidated financial statements.

Internal Control Over Financial Reporting

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

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

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

Compliance and Other Matters

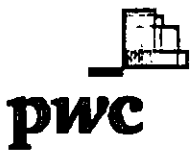
As part of obtaining reasonable assurance about whether the Health System's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material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

Purpose of this Report

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2019



Report of Independent Auditors on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance in Accordance with the Uniform Guidance

To the Board of Trustees of
Dartmouth-Hitchcock Health and subsidiaries

Report on Compliance for Each Major Federal Program

We have audited Dartmouth-Hitchcock Health and its subsidiaries' (the "Health System") compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the Health System's major federal programs for the year ended June 30, 2019. The Health System's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations 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 the Health System'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 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 the Health System'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 Dartmouth-Hitchcock Health and its subsidiaries compliance.

Opinion on Each Major Federal Program

In our opinion, Dartmouth-Hitchcock Health and its subsidiaries 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 June 30, 2019.

Report on Internal Control Over Compliance

Management of the Health System are responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Health System'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 the Health System's internal control over compliance.

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

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

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.

PricewaterhouseCoopers LLP

Boston, Massachusetts
March 31, 2020

Part III
Findings and Questioned Costs

Dartmouth-Hitchcock and Subsidiaries
Schedule of Findings and Questioned Costs
Year Ended June 30, 2019

I. Summary of Auditor's Results

Financial Statements

Type of auditor's report issued	Unmodified opinion
Internal control over financial reporting	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Noncompliance material to financial statements	No

Federal Awards

Internal control over major programs	
Material weakness (es) identified?	No
Significant deficiency (ies) identified that are not considered to be material weakness (es)?	None reported
Type of auditor's report issued on compliance for major programs	Unmodified opinion
Audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No

Identification of major programs

CFDA Number	Name of Federal Program or Cluster
Various CFDA Numbers	Research and Development
93.800	Organized Approaches to Increase Colorectal Cancer Screening
93.788	Opiod STR
93.110	Maternal and Child Health Federal Consolidated Programs
Dollar threshold used to distinguish between Type A and Type B programs	$750,000
Auditee qualified as low-risk auditee?	Yes

Dartmouth-Hitchcock and Subsidiaries
Schedule of Findings and Questioned Costs
Year Ended June 30, 2019

II. Financial Statement Findings

None Noted

III. Federal Award Findings and Questioned Costs

None Noted

Dartmouth-Hitchcock and Subsidiaries
Summary Schedule of Prior Audit Findings and Status
Year Ended June 30, 2019

There are no findings from prior years that require an update in this report.

DARTMOUTH-HITCHCOCK (D-H) | DARTMOUTH-HITCHCOCK HEALTH (D-HH) BOARDS OF TRUSTEES AND OFFICERS

Effective: January 1, 2020

Mark W. Begor, MBA MHMH/DHC Trustee *Chief Executive Officer, Equifax*	**Jennifer L. Moyer, MBA** MHMH/DHC Trustee *Managing Director & CAO, White Mountains Insurance Group, Ltd*
Jocelyn D. Chertoff, MD, MS, FACR MHMH/DHC (Clinical Chair/Center Director) Trustee *Chair, Dept. of Radiology*	**Robert A. Oden, Jr., PhD** MHMH/DHC/D-HH Trustee *Retired President, Carleton College*
Duane A. Compton, PhD MHMH/DHC/D-HH Trustee *Ex-Officio: Dean, Geisel School of Medicine at Dartmouth*	**David P. Paul, MBA** MHMH/DHC Trustee *President & COO, JBG SMITH*
William J. Conaty MHMH/DHC/D-HH Trustee *President, Conaty Consulting, LLC*	**Charles G. Plimpton, MBA** MHMH/DHC/D-HH Boards' Treasurer & Secretary *Retired Investment Banker*
Joanne M. Conroy, MD MHMH/DHC/D-HH Trustee *Ex-Officio: CEO & President, D-H/D-HH*	**Richard J. Powell, MD** (Roshini Pinto-Powell, MD) D-HH Trustee *Section Chief, Vascular Surgery; Professor of Surgery and Radiology*
Paul P. Danos, PhD MHMH/DHC/D-HH Trustee *Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth*	**Thomas Raffio, MBA, FLMI** MHMH/DHC Trustee *President & CEO, Northeast Delta Dental*
Elof Eriksson, MD, PhD MHMH/DHC Trustee *Professor Emeritus, Harvard Medical School and Chief Medical Officer, Applied Tissues Technologies, LLC*	**Kurt K. Rhynhart, MD, FACS** MHMH/DHC (D-H Lebanon Physician Trustee Representative) Trustee *DHMC Trauma Medical Director and Divisional Chief of Trauma and Acute Care Surgery*
Senator Judd A. Gregg MHMH/DHC Trustee *Senior Advisor to SIFMA*	**Edward Howe Stansfield, III, MA** MHMH/DHC/D-HH Boards' Chair *Senior VP, Resident Director for the Hanover, NH Bank of America/Merrill Lynch Office*
Roberta L. Hines, MD MHMH/DHC Trustee *Nicholas M. Greene Professor and Chair, Dept. of Anesthesiology, Yale School of Medicine*	**Pamela Austin Thompson, MS, RN, CENP, FAAN** MHMH/DHC/D-HH Trustee *Chief executive officer emeritus of the American Organization of Nurse Executives (AONE)*
Cherie A. Holmes, MD, MSc MHMH/DHC/(Community Group Practice) Trustee *Medical Director, Acute Care Services, D-H Keene/Cheshire Medical Center*	**Jon W. Wahrenberger, MD, FAHA, FACC** MHMH/DHC (Lebanon Physician) Trustee *Clinical Cardiologist, Cardiovascular Medicine*
Jonathan T. Huntington, MD, PhD, MPH MHMH/DHC (Lebanon Physician) Trustee *Acting Chief Medical Officer, DHMC*	**Marc B. Wolpow, JD, MBA** MHMH/DHC/D-HH Trustee *Co-Chief Executive Officer of Audax Group*
Laura K. Landy, MBA MHMH/DHC/D-HH Trustee *President and CEO of the Fannie E. Rippel Foundation*	

CURRICULUM VITAE AND BIBLIOGRAPHY
3/2018

Alena Katherine Neton Shoemaker, MD
Family Physician and Clinical Faculty, Lawrence Family Medicine Residency
[redacted]

EDUCATION

2006	Bachelor of Science	John Carroll University, University Heights, OH
2011	Doctor of Medicine	The Ohio State University School of Medicine, Columbus, OH

POSTDOCTORAL TRAINING

Residency:
6/2011 – 6/2014 Family Medicine
Greater Lawrence Family Medicine Residency, Lawrence MA

Fellowship:
10/2014 – 10/2015 Holistic, Integrative, and Pluralistic Medicine
Greater Lawrence Family Health Center (GLFHC), Lawrence MA

LICENSURE AND CERTIFICATION

2014 – present Medical Board of Massachusetts, American Board of Family Medicine

HOSPITAL APPOINTMENTS

2014 - present Associate Staff, Dept of Family Medicine, Lawrence General Hospital

TEACHING RESPONSIBILITIES

Regular Clinical Teaching:
Community and Obstetric Faculty at the Lawrence Family Medicine Residency Program
Community Faculty for Tufts University School of Medicine
Faculty Director of Integrative Medicine Curriculum and Resident OMM Clinic

Presentations:
Oct 2015 OMT for the primary care physician, co-presenter, FMEC 2015 Danvers, MA

PROFESSIONAL SOCIETIES

American Academy of Family Physicians
Integrative Medicine for the Underserved

MAJOR RESEARCH INTERESTS

Integrative medicine, non-pharmacologic management of pain, group medical visits, Osteopathy

BIBLIOGRAPHY

Geller JS, Kulla J, Shoemaker A. Group Medical Visits Using an Empowerment-based Model as Treatment for Women with Chronic Pain in an Underserved Community. *Global Advances in Health and Medicine*: 2015 Nov; 4(6): 27-31, 60

Heather Markey Waniga, RN, MSN, Travis Gerke, ScD, Alena Shoemaker, MD, Derek Bourgoine, MHA and Pracha Emranond, MD, MPH . The Impact of Revised Discharged Instructions on Patient Satisfaction. *Journal of Patient Experience*: 2016, Vol 3 (3): 64-48

LANGUAGES SPOKEN

English, Medical Spanish

CURRICULUM VITAE

NAME: Daisy J. Goodman, CNM, WHNP, DNP, MPH

ADDRESS: [redacted]

PHONE:
Home: [redacted]
Cell: [redacted]

EMAIL: [redacted]

LICENSURE and CERTIFICATION
NH - APRN 045116-23
NH - RN 045116-21
ACNM certificate #10710
NCC certificate # GOO104259401

EDUCATION

Institution	Degree/Certification	Date
Geisel School of Medicine at Dartmouth	MPH	2014
Massachusetts General Hospital (MGH) Institute of Health Professions	DNP	2010
State University of New York at Stony Brook	MS	2004
Frontier School of Midwifery and Family Nursing	CNM WHNP	2002 2002
N.H. Community Technical College	AD-RN	1998
Yale University	BA	1985
College of the Atlantic	—	1982

TEACHING EXPERIENCE

Institution	Title	Date
Colby-Sawyer College, Clinical Nurse Leader Program	Adjunct Professor of Nursing *Applied Healthcare Improvement*	2017
The Dartmouth Institute for Health Policy and Clinical Practice	Clinical Assistant Professor Instructor *Continual Improvement of Health Care* *MPH Practicum* *Coproducing Healthcare Service in Systems*	2016-present 2015-2016
	Teaching Assistant: *Epidemiology/Biostatistics* *Statistical Methods for Quality Improvement* *Continual Improvement of Health Care (2013-2104)*	2013-2015
Masters in Healthcare Delivery Science Program at Dartmouth	Curriculum Specialist	2015
Geisel School of Medicine at Dartmouth	Clinical Assistant Professor Instructor Obstetrics and Gynecology Community and Family Medicine	2016 2013-2016
	Co-facilitator: *History, Society and the Physician*	2016
Frontier Nursing University	Teaching Associate: *Professional Role Development* *Health Promotion* *Community Assessment* *Health Policy: the Birth Center as Case Study*	2013- 2014
Philadelphia University, Continuing Medical/Professional Education	Adjunct Faculty *Pharmacology in Women's Health*	2011-2013
Tufts School of Medicine	Clinical Instructor	2011-2012

CLINICAL EXPERIENCE

Dartmouth Hitchcock Medical Center Department of Obstetrics and Gynecology Perinatal Addiction Treatment Program	Certified Nurse Midwife	2013-present
Franklin Health Women's Care Franklin Memorial Hospital	Certified Nurse Midwife	2006- 2013
Swift River Health Care Rumford Hospital	Certified Nurse Midwife	2002-2006
Maine General Medical Center	Registered Nurse, MCH	2002
Weeks Memorial Hospital	Staff Nurse, Maternity	2000
Weeks Medical Center	Office Nurse, Primary Care	1999- 2000
Coos County Nursing Hospital	Staff/Charge Nurse	1997-2000
Weeks Memorial Hospital	Staff Nurse, Medical Surgical	1998-1999

FELLOWSHIPS

Veterans Health Administration	Quality Scholars Fellow	2012- 2015

HONORS AND AWARDS

2015 Blatman Scholar's Award: Dept. of Obstetrics and Gynecology, Dartmouth Hitchcock Medical Center

2014 The Dartmouth Institute for Health Policy and Clinical Practice: Leadership Award

2012 Maine Affiliate, American College of Nurse -Midwives: Midwife of the Year Award

2010 MGH Institute of Health Professions: Lavinia Dock Scholarly Writing Award

2008 MGH Institute of Health Professions: Clapham Merit Scholarship

2001 Frontier School of Midwifery and Family Nursing: Mardi Perry Scholarship

1998 New Hampshire Technical College: Nursing Faculty Award Scholarship

1997 Androscoggin Valley Hospital Scholarship Award

PUBLICATIONS

Murphy, J, **Goodman, D**, Johnson, T, Terplan, M. The Comprehensive Addiction Treatment Recovery Act (CARA): No one called the midwife *(under review)*.

Goodman, D, Bowden, K, O'Connor, A. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives, 2nd ed.* New Jersey: Wiley-Blackwell *(under review).*

Goodman, D, Ogrinc, G, Davies, L, et al. Explanation and Elaboration of the SQUIRE [Standards for Quality Improvement Reporting Excellence] Guidelines, version 2.0: Examples of SQUIRE elements in the healthcare improvement literature. *BMJ Quality and Safety,* 2016;0: 1–24.

Goodman, D. Substance use disorders. In Thorpe, N, Farley, C, Jordan, R. *Clinical Practice Guidelines for Midwifery and Women's Health (5th ed).* 2016. Jones and Bartlett.

Goodman, D. Improving access to maternity care for pregnant women with opioid use disorders: co-location of midwifery services in the Dartmouth-Hitchcock Perinatal Addiction Treatment Program. *Journal of Midwifery and Women's Health,* 2015;60;6:706-712.

Goodman, D, Milliken, C, Theiler, R, Nordstrom, B, Akerman, S. A Multidisciplinary Approach to the Treatment of Co-occurring Opioid Use Disorder and Posttraumatic Stress Disorder in Pregnancy: A Case Report. *Journal of Dual Diagnosis* 2015 (ePub ahead of print).

Akerman, S, Brunette, M, Green, A., **Goodman, D,** Blunt, Heil, S. Treating tobacco use disorder in pregnant women on opioid substitution therapy: A systematic review. *Journal of Substance Abuse Treatment* 2015; 52:40-7.

Ogrinc, G, Davies, L, **Goodman, D**, Batalden, P, Davidoff, F, Stevens, D. SQUIRE 2.0: (Standards for Quality Improvement Reporting Excellence): Revised Publication Guidelines from a Detailed Consensus Process. *The Joint Commission Journal on Quality and Safety* 2015;41;10:471-479.

Davies, L, Donnelly, K, **Goodman, D**, Ogrinc, G. Findings from a novel approach to publication guideline revision: User road testing of a draft version of SQUIRE 2.0. *BMJ Quality and Safety* 2015 (ePub ahead of print).

Bowden, K., **Goodman, D**. Barriers to employment for postpartum women with substance use disorders. *Work: A Journal of Assessment, Prevention & Rehabilitation* 2015; 50; 3: 425-31

Akerman, S, **Goodman, D**. Treating Opioid Use Disorders in Pregnant Women: Are We Doing Enough? *Newsletter of the American Association of Addiction Psychiatry* June, 2014.

Goodman, D, Wolff, K. Screening for substance abuse in women's health: a public health imperative. *Journal of Midwifery and Women's Health* 2013;58;3:278-287.

Goodman, D, O'Connor, A, Bowden, K. Substance abuse during pregnancy. In Engstrom, J, Marfel, J, Jordan, R. *Prenatal and Postnatal Care: A Guide for Nurse Practitioners and Midwives.* 2013. New Jersey: Wiley-Blackwell.

Goodman, D. (contributor). The Capstone Project: Students' Experience. (2012). In Ahmed, S, Andrist, L, Davis, S, Fuller, V. (Eds). *The DNP – Redesigning Advance Practice Roles for the 21st Century: Education, Practice, and Policy.* 2012. New York: Springer.

Goodman, D. Buprenorphine for the treatment of perinatal opioid dependence: pharmacology and implications for antepartum, intrapartum, and postpartum care. *Journal of Midwifery and Women's Health,* 2010;56;3: 240-247.

Technical Reports:

Snuggle ME Workgroup (2013). *Embracing Drug Affected Babies and their Families in the First Year of Life to Improve Medical Care and Outcomes in Maine.* (Contributing author).

MPH Capstone:

An Integrated Care Model for Treating Perinatal Substance Use Disorders: A Public Health Program Intervention Proposal. (2014). *Fulfillment of the Masters in Public Health degree, Geisel School of Medicine at Dartmouth.*

DNP Capstone:
Managing Perinatal Opioid Dependency in the Rural Community Setting: Clinical Guideline Development and Validation. (2009). *Fulfillment of the Doctor of Nursing Practice degree, Massachusetts General Hospital Institute for Healthcare Professionals.*

PRESENTATIONS

2017 American College of Nurse Midwives National Convention: "Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders: Expanding the Role of Midwives." (5/2017)

2017 American Society for Addiction Medicine National Conference (poster presentation): "Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program (Co-author: Julia Frew, MD)

2017 Institute for Healthcare Improvement Virtual Expedition: "Nurturing Trust." (3/2017)

2016 Institute for Healthcare Improvement National Forum: "Can Improvement Cause Harm?" (Co-presenters Greg Ogrinc and William Nelson). (12/2016)

2016 Institute for Healthcare Improvement Scientific Symposium: "The SQUIRE Guidelines." (Co-presenters Greg Ogrinc and Louise Davies). (12/2016)

2016 Northern New England Perinatal Quality Improvement Network: "A Collaborative Project to Improve Quality and Safety for Pregnant and Parenting Women with Opioid Use Disorders: Project update." (11/2016)

2016 American Association of Colleges of Nursing: "The Nation's Opioid Crisis: Your Practice, Your Responsibility." Webinar (10/2016)

2016 ACNM/AWHONN Maine: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders. (10/2016)

2016 NIDA Clinical Trials Network, Northeast Node: Integrated Care for Pregnant and Parenting Women with Opioid Use Disorders (10/2016)

2016 Institute for Healthcare Improvement: WIHI program on integrated care models for treatment of perinatal substance use (6/2016)

2016 Quality and Safety in Nursing Education: Demystifying the SQUIRE guidelines. (5/2106)

2016 Northeast Medical Association (NEMA) annual meeting: "Moms and Moms-to-be in Recovery: Perinatal Addiction Treatment Programs" (3/2016)

2016 NNEPQIN Winter Conference: "A collaborative project to improve safety and quality of care for pregnant and postpartum women with opioid use disorders" (1/2016)

2015 Institute for Healthcare Improvement (IHI) 27th National Forum: faculty, SQUIRE writing workshop (12/2015)

2015 International SQUIRE writing conference: faculty, 11/2015

2015 "Revising the SQUIRE Guidelines for quality improvement reporting excellence: a case study in improvement" Oral presentation at the Academy for Healthcare Improvement (AHI) National Conference, 10/2015

2015 "Treatment of Perinatal Opioid Use Disorders" Oral presentation at American College of Nurse Midwives' National Conference, 6/2015

2015 "Double Jeopardy: The intersection of PTSD, substance use disorders, and pregnancy" Poster presentation at American College of Nurse Midwives' National Conference, 6/2015

2015 SQUIRE publication guidelines (with Greg Ogrinc, MD). Grand Rounds presentation, Center for Clinical Research and Technology, University Hospitals Case Medical Center, 5/2015

2015 SBIRT in Healthcare: focus on perinatal care. 11th Annual Dartmouth Symposium "Taking Action to Reduce Opioid-related Harm," 5/2015

2015 "In their own words: a qualitative study of the experience of prenatal care for women with opioid use disorders." Grand Rounds presentation, Department of Obstetrics and Gynecology, Dartmouth Hitchcock Medical Center, 3/2015.

2014 "SBIRT in Everyday Practice." Oral presentation at ChaD regional conference: Optimizing Our Interactions with Families with Substance Use Disorders, 11/2014.

2014 "Caring for Mothers with Opioid Use Disorders: A Collaborative Model." Oral presentation at Joint ACOG/AWHONN Regional Conference, 10/2014

2014 "Improving Quality of Care for Pregnant Women with Substance Use Disorders" Guest lecture for Quality Improvement course, MGH Institute for Health Professions, 7/2014

2014 "Integrating Substance Abuse Screening, Brief Intervention and Referral for Treatment in Maternity Care." Poster presentation for Academy for Healthcare Improvement, 5/2014

2014 "Screening for Substance Use Disorders in Women's Health." Oral presentation at American College of Nurse Midwives' National Conference, 5/2014

2013 "Screening, Brief Intervention and Referral for Treatment in Maternity Care" Webinar, sponsored by Maine Quality Counts

2013 Panelist, Advanced Practice Nursing Leadership Panel for University of Southern Maine (USM), Graduate Nursing Program, Portland, ME

2012 "Screening for Substance Abuse in Pregnancy" Oral presentation, Joint AWHONN/ACOG Regional Perinatal Conference, Freeport, ME 5/2012

2011 Education session, ACNM National Convention. "A collaborative approach for treating perinatal opioid addiction in the community setting," San Antonio, TX 5/2011

2011 ACNM Regional Conference. "Treating perinatal opioid dependence with buprenorphine," Portsmouth, NH, 10/2011

2010 Central Maine Medical Center Clinical Grand Rounds, "A collaborative model for treatment of perinatal opioid dependence in the rural community setting," Lewiston, ME

2010 Guest lecture, MGH Institute for Health Professions, Women's Health Nurse Practitioner Program: "Supporting women's addiction recovery: the role of the WHNP," Boston, MA

2010 New England Regional Perinatal Conference: "Treating perinatal opioid dependence in the rural community," Waterville, ME

2010 Maine AWHONN Supper Club presentation, "Managing perinatal opioid dependence in the community setting," Farmington, ME

OTHER SCHOLARLY ACTIVITIES:

2013-2017 SQUIRE 2.0 Revision Leadership Group

2015-2017 Abstract Review, QSEN (Quality & Safety in Nursing Education) Institute

2013-2016 Abstract Review, International Forum on Quality and Safety in Healthcare

2016 Reviewer, Journal of Substance Abuse Treatment

2011-2017 Reviewer, Journal of Midwifery and Women's Health

RESEARCH AND QUALITY IMPROVEMENT ACTIVITIES

2017 Empowering pregnant mothers with opioid use disorders to create and implement a Plan of Safe Care for their infants using technology *(Co-Principal Investigator with Sarah Lord, PhD).* SYNERGY Community Engagement Pilot Grant.

2016 HERIZONT: National Institute for Alcohol Abuse and Alcoholism clinical trial. *(Sub-investigator; Principal Investigators: Alan Green,MD; Sarah Akerman, MD).*

2015-2016 Improving Safety and Quality in the Care of Pregnant Women with Substance Use Disorders. A quality improvement project. *(Principal Investigator).* March of Dimes, New England Chapter

2014 In their own words: Perceived barriers to care for pregnant women with opioid dependence. A qualitative study of barriers and facilitators to care for prenatal and postpartum women with opioid dependence *(Principal Investigator).* Dartmouth-Hitchcock Medical Center, Department of Obstetrics and Gynecology: Blatman Scholars Fund

2014 Reward responsiveness in pregnant cigarette smokers treated with buprenorphine. Co-investigator. *(Principal Investigator: Sarah Akerman, MD)*

2009 Managing Perinatal Opioid Dependency in the Rural Community Setting: Clinical Guideline Development and Validation *(DNP Capstone).* MGH Institute for Health Professions

Clinical Improvement Work

2014 Perinatal Outcomes, Dartmouth Hitchcock Perinatal Addiction Treatment Program (data analysis, reporting). Funded by New Hampshire Charitable Foundation.

2013-2017 Project Coordinator, Dartmouth Hitchcock Medical Center, Department of Obstetrics and Gynecology, SBIRT Implementation Project. Funded by New Hampshire Charitable Foundation.

2011-2012 Project Director, Franklin Health Women's Care, 4Ps Plus Screening Project.

OTHER PROFESSIONAL ACTIVITIES

Professional Organizations

2002-current Member, American College of Nurse-Midwives

2014-current Member, American Society for Addiction Medicine

Policy and Advisory Board Memberships

2016- ACNM representative to Alliance for Innovation in Maternal Health (AIM) workgroup, bundle development workgroup for the Care of Women with Opioid Use Disorders

2013-2016 NH Statewide Partnership on Prenatal Substance Exposure/Alcohol Exposure

2011-2013 Maine Drug-Affected Babies Project- multidisciplinary work group on perinatal substance abuse

2009 Maine State Board of Nursing- APRN Advisory Board

PRECEPTORSHIPS:

2014 Clinical Preceptor, Nurse-Midwifery students, Yale University Nurse-Midwifery Program

2012 Clinical Preceptor, Women's Health, MGH Institute of Health Professions

2010 Clinical Preceptor, University of Vermont, Family Nurse Practitioner Program

2009 Clinical Preceptor, Husson College, Family Nurse Practitioner Program

2009-2012 Clinical Instructor, Maine Sexual Assault Forensic Nurse Examiner Program

CURRICULUM VITAE

Date Prepared: September 7, 2017

NAME: Julia Renee Frew, MD

ADDRESS: Office: Department of Psychiatry
Geisel School of Medicine at Dartmouth
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756
[redacted]

Home: [redacted]

EDUCATION:

DATE	INSTITUTION	DEGREE
1992-1996	Kenyon College	B.A., summa cum laude
1998-1999	New York University	Postbaccalaureate Premedical Program
2000-2005	Brown Medical School (Brown-Dartmouth Program in Medical Education)	M.D.

POST-DOCTORAL TRAINING:

DATE	SPECIALTY	INSTITUTION
2006-2010	Psychiatry	Geisel School of Medicine at Dartmouth
2009-2010	Psychiatry- Chief Resident	Geisel School of Medicine at Dartmouth

LICENSURE AND CERTIFICATION:

DATE	LICENSURE/CERTIFICATION
2010-	New Hampshire Board of Medicine #14795
2010-	Vermont Board of Medical Practice #042-0011941
2011-	Diplomate, American Board of Psychiatry and Neurology (Psychiatry)

ACADEMIC APPOINTMENTS:

DATE	ACADEMIC TITLE	INSTITUTION
2009-2011	Instructor in Psychiatry	Geisel School of Medicine at Dartmouth
2011-	Assistant Professor of Psychiatry	Geisel School of Medicine at Dartmouth
2016-	Assistant Professor of Obstetrics and Gynecology	Geisel School of Medicine at Dartmouth
2017-	Assistant Professor of Medical Education	Geisel School of Medicine at Dartmouth

HOSPITAL APPOINTMENTS:

DATE	HOSPITAL TITLE	INSTITUTION
2010	Inpatient Psychiatrist (per diem)	Central Vermont Medical Center
2010-	Attending Psychiatrist	Dartmouth-Hitchcock Medical Center
2010-	Director, Women's Mental Health Program	Dartmouth-Hitchcock Medical Center
2010-2015	Consulting Psychiatrist, Live Well/ Work Well Employee Wellness Program	Dartmouth-Hitchcock Medical Center
2016-	Medical Director, Perinatal Addiction Treatment Program	Dartmouth-Hitchcock Medical Center

COMMITTEE ASSIGNMENTS:

DATE	COMMITTEE	INSTITUTION
2008-	Education Policy Committee	Geisel Department of Psychiatry
2009-2010	Residency Curriculum Committee	Geisel Department of Psychiatry
2009-2010	Quality Improvement Committee	Dartmouth-Hitchcock Psychiatric Associates
2009-2010	Psychiatry Grand Rounds Committee	Geisel Department of Psychiatry
2010-2011	Guardianship Policy Committee	Dartmouth-Hitchcock Medical Center
2011-2016	Faculty Council (Psychiatry representative)	Geisel School of Medicine at Dartmouth
2012-	Clinical Education Course Director Committee	Geisel School of Medicine at Dartmouth
2012-	Psychiatry Residency Selection Committee	Geisel Department of Psychiatry
2013-	Graduate Medical Education Committee	Dartmouth-Hitchcock Medical Center
2013-	Chair, Residency Program Clinical Competency Committee	Geisel Department of Psychiatry
2014-	Residency Program Evaluation Committee	Geisel Department of Psychiatry
2015-	Graduate Medical Education Curriculum Committee	Dartmouth-Hitchcock Medical Center

MEMBERSHIP IN PROFESSIONAL SOCIETIES:

DATE	SOCIETY	ROLE
2008-2010	American Psychiatric Association	Member-in-Training
2009-	North American Society for Psycho-Social Obstetrics & Gynecology	Member
2010-2015	Academy of Psychosomatic Medicine	Member, Founding Member of Women's Mental Health Special Interest Group
2012-	International Association for Women's Mental Health	Member
2013-	Association of Directors of Medical Student Education in Psychiatry	Member

2013-	American Association of Directors of Psychiatry Residency Training	Member
2014-	Postpartum Support International	Member

AWARDS AND HONORS:

DATE	AWARD
1992-1996	National Merit Scholarship
1992-1996	Kenyon College Honors Scholarship
1996	Phi Beta Kappa
2000	Volunteer of the Year, St. Vincent's Hospital and Medical Center, NYC
2004	"Best Platform Research Presentation", Academy of Breastfeeding Medicine Annual Meeting
2005	Patricia McCormick Prize, given to the outstanding female student in the graduating class of Brown Medical School
2016	Inducted into Geisel Academy of Master Educators

CLINICAL AND RESEARCH INTERESTS

Women's mental health, perinatal addiction treatment, psychosomatic medicine, physician and medical student health and wellness, psychiatric education of medical students and residents

TEACHING EXPERIENCE/CURRENT TEACHING RESPONSIBILITIES

Geisel School of Medicine at Dartmouth:

DATE	TEACHING
2010-	OB/Gyn Residency Program: Teach on perinatal psychiatry topics
2012	Created and implemented Frontiers in Brain and Behavior preclinical elective for first and second year medical students
2012-	Co-director, Psychiatry Clerkship - Didactic and small group teaching since 2008 - Assumed Co-directorship in 2012: assist with administration of the course including attending weekly clerkship oversight meetings, grading student write-ups, overseeing residents involved in teaching in the clerkship, and assigning final grades
2012-	Residency/Career Advisor for Geisel students interested in pursuing careers in psychiatry
2013-	SBM- Psychiatry Course Director - Facilitate small group sessions to teach 2nd year medical students psychiatric interviewing skills since 2006. - Teach topics such as psychiatric interviewing, delirium, psychiatric ethics since 2010 - Assumed Directorship of course in 2013: oversee all aspects of the course including faculty recruitment, curriculum oversight, final examination, and small group interviewing component
2013-	Associate Director, Psychiatry Residency Program - Teach and directly supervise residents since 2010

- Assumed Associate Directorship in 2013: assist with administration of Adult Psychiatry Residency Program including participating in recruitment, designing and implementing evaluation methods for residents, overseeing teaching activities of senior residents, and meeting regularly with residents regarding their progress

2013- SBM Reproduction Course: Teach session on perinatal psychiatry

2013- Travel yearly to Providence, RI to provide mock oral board exams for Brown Psychiatry Residents

2014-2017 Co-Director, Scientific Basis of Medicine Program (2nd year medical school curriculum at Geisel School of Medicine)

- Oversee Scientific Basis of Medicine Program, including course review, recruitment and evaluation of PBL tutors, review of examinations, determination of final grades, advising for students, and strategic planning

West Central Behavioral Health:

DATE	TEACHING
2009	Led inservice training sessions for case managers at community mental health center on psychopharmacology and substance abuse
2009	Provided psychoeducation about psychopharmacology to clients in Illness Management and Recovery Program

INVITED PRESENTATIONS

Local/Regional

DATE	TOPIC	ORGANIZATION	LOCATION
2011	Depression 101: Treatment of Depression	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Effective Treatment of Anxiety	DHMC Live Well/Work Well Program	Lebanon, NH
2011	Women's Mental Health	DHMC Live Well/Work Well Program	Lebanon, NH
2012	Postpartum Depression	Geisel OB/Gyn Interest Group	Hanover, NH
2012	Access to Mental Health Care for Perinatal Women	Northern New England Perinatal Quality Improvement Network	Lebanon, NH
2012	Access to Mental Health Care for Perinatal Women	OB/Gyn Grand Rounds	Lebanon, NH
2012-14	Women's Mental Health In Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon & Manchester, NH
2013	Perinatal Psychiatry	Geisel OB/Gyn and Psychiatry Interest Groups	Hanover, NH
2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds Dartmouth-Hitchcock	Lebanon, NH

2014	Management of Bipolar Disorder in Pregnancy and Lactation	Psychiatry Grand Rounds University of Vermont	Burlington, VT
2015	Assessment and Management of Depression and Anxiety in Primary Care Patients; Management of Stressful Encounters and Difficult Patients in Primary Care	"What's New in Psychiatry for Non-Psychiatric Providers" CME event	Lebanon, NH
2016	Perinatal Psychiatric Illness	Mental Health Center Of Greater Manchester Grand Rounds	Manchester, NH
2017	Building a Life Worth Living: Treating Moms With Opioid Use Disorders	New Hampshire Association for Infant Mental Health	Concord, NH
2017	Moms in Recovery: Treatment for Pregnant and Parenting Women with Substance Use Disorders: Typical Treatment Dilemmas	Dartmouth-Hitchcock Pediatric Schwartz Rounds	Lebanon, NH
2017	Co-occurring Disorders In Perinatal Women with Substance Use Disorders	Perinatal Opioid Use Disorders Learning Collaborative	Lebanon, NH/Webinar
2017	Tackling the New Hampshire Opioid Crisis (Perinatal Addiction Treatment)	Northeast Node/NIDA Clinical Trials Node/ Center for Technology and Behavioral Health	Hanover, NH
2017	No Health without Mental Health (Perinatal Addiction Treatment)	Dartmouth-Hitchcock Departments of Psychiatry and Population Health	Lebanon, NH
2017	Opiate Crisis: Stories and Solutions (panel discussion)	VT PBS	Rutland, VT

National/International

DATE	TOPIC	ORGANIZATION	LOCATION

2004	First Steps Breastfeeding Education Project	Academy of Breastfeeding Medicine Annual Meeting	Orlando, FL
2016	Moms and Moms-to-Be in Recovery: a Perinatal Addiction Treatment Program	North American Society for Psychosocial Obstetrics and Gynecology	New York, NY
2016	The Earlier the Better: Developing a system of integrated care for child-bearing families with substance use disorders	National Drug Abuse Treatment Clinical Trials Network/ Center for Substance Abuse Treatment	Webinar
2017	Pregnancy and Psychiatric Medication	Recovery Library by Pat Deegan	Online resource

BIBLIOGRAPHY

Original Articles:

Frew, J & Taylor, J. First Steps: A program for medical students to teach high school students about breastfeeding. *Medicine and Health / Rhode Island*. 2005; 88:48-50.

Frew, J. Psychopharmacology of Bipolar I Disorder During Lactation: a case report of use of lithium and aripiprazole in a nursing mother. *Archives of Women's Mental Health.* 2015; 18(1):135-136.

Posters:

Frew, J & Taylor, J. First Steps Breastfeeding Education Project. Society of Teachers of Family Medicine Predoctoral Education National Conference, New Orleans, LA. 2004.

Larusso, E, Frew, J & Krishnan, N. Integrating Mental Health Care into Obstetrics & Gynecology: Results from an embedded psychiatry consultation clinic and implications for quality improvement. North American Society for Psychosocial Obstetrics & Gynecology Annual Meeting, Providence, RI. 2012.

Frew, J & LaRusso, E. Psychiatric consultation in obstetrics/gynecology (OB/GYN): Updated results from a reproductive psychiatry consultation clinic and implications for quality improvement. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Frew, J. Psychopharmacology of bipolar I disorder during lactation: A case report of use of lithium and aripiprazole in a nursing mother. Perinatal Mental Health Meeting, Chicago, IL. 2013.

Goodman, D & Frew, J. Dismantling Barriers to Addiction Treatment and Maternity Care: Results from an Integrated Program. American Society of Addiction Medicine, New Orleans, LA. 2017.

LUCY J.R. PILCHER, MSW, LICSW

[redacted]

EDUCATION

University of Denver, Graduate School of Social Work — **September 2012 – June 2014**
Masters of Social Work & Graduate Certificate of Trauma Informed Social Work Practice
University of Bath — **September 2006 – May 2009**
Bachelors of Social Work and Applied Social Studies

RELEVANT EXPERIENCE

Dartmouth Hitchcock Medical Center, Lebanon, NH — **October 2018– Present**
Department of Psychiatry, Addiction Treatment Services, Moms in Recovery Program

- Provide clinical addiction treatment services to women with substance use disorders with a focus on promoting safe and healthy pregnancy and parenting.
- Facilitator of group therapy sessions at varying levels of addiction treatment ranging from intensive outpatient treatment (IOP) groups to maintenance groups with a focus on healthy relationships, motivational enhancements, Cognitive Behavioral Therapy and attachment and trauma informed parenting.
- Assessing individual clients, developing and implementing individualized treatment plans with a focus on achieving and maintaining sobriety, developing and maintaining safe and healthy relationships and providing consistent, safe care to children.
- Speaker and panelist at various community events sharing expertise on addiction treatment, parenting and trauma-informed practice with children and families.
- Certified facilitator of Circle Of Security Parenting Program, an 8 week attachment focused program aimed at supporting parents to gain the tools to understand their child's behaviors and see the underlying emotions and unmet needs.
- Consistently utilizing a strengths based model to empower and build on strengths whilst honestly assessing for risk and creating safety plans including engagement with community partners as needed.
- Assessing vulnerable adults and children and working with child and adult protective services as required.

Upper Valley Pediatrics, Bradford, VT — **March 2016– Present**
LICSW Clinical Mental Health Professional

- Providing individual and family therapy to children and young adults aged between 5-25 years experiencing a variety of mental health diagnoses including depression, anxiety, PTSD, disordered eating, family dysfunction, bipolar disorder and panic disorder.
- Collaborating with medical team, school and community agencies to provide comprehensive mental health support, behavioral plans and structure for children and young people accessing therapy.
- Utilizing CBT, TF-CBT, Interpersonal Therapy, Motivational Interviewing, Solution Focused, Family Systems Therapy, Mindfulness based practice and Play Therapy integrated with a fundamental strengths based approach to support clients in achieving goals.

Dartmouth Hitchcock Medical Center, Lebanon, NH — **June 2014– Present**
Pediatric Oncology, Birthing Pavilion, Emergency Department, Pediatrics/PICU, On-call MSW

- Social Worker on-duty hospital wide out of hours including coverage of adult and pediatric ICU's, Birthing Pavilion, Emergency Department alongside all other hospital units. Provide brief, targeted intervention to assist patients, families and medical teams as needed to promote excellent patient care, family support, connection to community services and timely and appropriate discharge.
- Efficiently complete thorough biopsychosocial assessments and create and implement plan of intervention to holistically meet needs, promote patient and family care and increase connection to and utilization of community services.
- Assessing for presence of child or adult neglect and/or abuse including formal Childs Abuse Protection and Prevention assessments and collaborating with child and adult protective services as needed while maintaining a strengths based and transparent approach.
- Providing holistic support to families of patients admitted to all units for multiple complex issues including substance use, mental health issues, infant substance withdrawal, physical trauma, chronic illness, scheduled surgeries and co-morbid conditions.
- Supporting families in end of life time periods including bereavement counseling, practical assistance and clinical interventions.
- Participate in collaborative efforts to maintain effective and appropriate utilization of services and to overcome barriers to facilitate discharge as needed.
- Create and sustain strong connections with community organizations to assist patients to access services that meet basic and higher level needs in their medical home or community.
- Providing supervision and training of new staff members working with senior management to effectively orient and ensure new staff attain a high level of professional practice in line with the organizations goals and objectives.

Maple Leaf Children's Center, Thetford, VT — **September 2017– Present**

Chair, Board of Directors

- Chair of the Board of Directors of non-profit Children's Center providing high quality, accredited care to children aged 18momths-4 years and their families.
- Supervise Executive Director in personnel management, financial sustainability, safeguarding, human resources and professional development.

Children's Hospital Colorado, Denver, CO **September 2013– June 2014**

MSW Internship NeuroOncology Clinical Social Work

- Providing psychosocial support and interventions to children and families experiencing a diagnosis of childhood cancer.
- Efficiently completing intake & ongoing assessments and coordinating utilization of community and national resources as needed.
- Collaborative working with medical teams and psychosocial services to meet the comprehensive needs of a diverse patient population.

Mile High United Way, Denver, CO **October 2012– June 2013**

MSW Internship

- Created a guidance toolkit in conjunction with Governor Hickenlooper's Office promoting best practices with homeless youth resulting in adoption of the toolkit as a federal national model by Housing & Urban Development.
- Designing & facilitating a prevention program for parenting youth, including community engagement, individual & group sessions.

Spurwink Services, Portland, ME **September 2011– June 2012**

***Behavioral Health Professional** (Jan – June), **Therapeutic Foster Parent** (Sept– Jan)*

- Facilitated daily sessions with groups & individuals with mental health diagnosis. Sessions focused on improving self-esteem, trauma therapy, human sexuality education & development of coping strategies & healthy social relationships.
- Advocated on behalf of & supported clients and families to actively participate in the decision making process related to care.
- Provided residential emotional and behavioral support to young people as they transitioned from psychiatric hospitalization.
- Maintained transparency of practice, effective communication and positive regard to aid movement towards family reunification.

Bath & NE Somerset Social Services, Bath, United Kingdom **January 2010 – June 2010**

***Referral and Assessment Team** (Jan 10-Jun 10) **BSW Internship** (Jan 09-June 09)*

- Successfully fulfilled requirements for case management of large caseload including Section 47 and Section 17.
- Delivered effective front line services that safeguard the welfare of vulnerable children and young people. Working within multi-disciplinary teams and in positive partnerships with colleagues from different professions and agencies.
- Operated under a relationship-based, strengths focused model to advocate for the rights of the child in the context of their family system.

Cornwall Social Services, Penzance, United Kingdom **September 2009-January 2010**

Agency Placement-Children in Need/Child Protection team

- Successfully fulfilled requirements for case management of large caseload including Section 47 and Section 17.
- Delivered effective front line services that safeguard the welfare of vulnerable children and young people. Working within multi-disciplinary teams and in positive partnerships with colleagues from different professions and agencies.

IvyBank Nursing Home, Bath, United Kingdom **September 2007-January 2008**

BSW Internship

- Provided individual sessions to elderly focusing on processing death, improving mental health and maintaining relationships.

Poppins Center for Autism, Cornwall, United Kingdom **February 2005-June 2009**

Residential Case Worker

- Performed intake assessments, created care plans and developed supportive, professional relationships with families and children with Autistic Spectrum Disorder accessing respite care services.

VOLUNTARY POSITIONS

Maple Leaf Children's Center, Thetford, VT **August 2017 – Present**
Board Member of non-profit community organization

DHMC Social Work Practice Council, Lebanon, NH **June 2017 – Present**
Member of OCM MSW Practice Council

DHMC Schwartz Rounds Committee Member, Lebanon, NH **September 2014 – February 2016**
Member of Pediatric Schwartz Rounds planning committee.

MARTHA SUE "SUZY" CATALONA
[redacted]

PROFESSIONAL GOAL:
To find an administrative leadership position on a synergistic operations team that values and expects excellence in an environment where commitment to continuous system and process improvement is obvious in daily operations.

WORK EXPERIENCE:

Management

* Stabilized systems and staffing in the Weight and Wellness Center, Sleep Medicine service and Addiction Treatment Programs after reorganizations.

* Collaborated with Primary Care administrative teams to implement and expand behavioral health service integration in Primary Care.

* Developed and maintained the infrastructure, systems and procedures to support the mission and promote the overall function of the Department of Psychiatry.

* Implemented a Corporate Compliance Program for the Department of Psychiatry including developing the plan, coordinating and facilitating medical record compliance audits with an outside consultant, organizing and leading the Compliance Committee and providing compliance training for all Department faculty and staff.

* Developed documentation templates for all services provided within the Department.

* Led administrative efforts associated with the initial implementation of an electronic medical record and appointment scheduling system and with the conversion to a new system several years later.

* Created and maintained master schedules for 65 providers.

* Negotiated and administered service contracts with outside facilities and agencies.

* Administered Training Affiliation Agreements for the Child and Adolescent Psychiatry Fellowship Training Program.

* Served as Department's Complaints Officer.

* Served as a resource to the Department on regulatory matters.

* Participated in the formation of a formal quality improvement program for the Department of Psychiatry

* Monitored day-to-day work flow and allocated resources to maximize productivity and insure timely task completion.

* Monitored and distributed monthly faculty productivity reports.

* Hired, trained, and managed department support staff.

* Assumed responsibility for UM program development, implementation, maintenance, evaluation, and improvement.

* Collaborated with clinicians in system-wide UM activities for those clients receiving services across the continuum of care in an integrated care delivery system.

* Collaborated with all involved individuals/departments to develop specific policies/guidelines for admission, utilization review, and care management processes.

* Developed and defined Access Office roles and functions.

* Established and maintained relationships with referral sources and third party payors.

* Managed intake and utilization review/case management functions for Inpatient, Partial Hospital, and Outpatient Psychiatry Services.

* In-serviced staff on utilization review process.

* Counseled and evaluated performance of professional nurses based on stated expectations and conducted annual appraisal interviews.

* Scheduled fifty staff to provide twenty-four hour coverage of Inpatient Psychiatry Services.

* Planned and coordinated assignments and activities to ensure safe patient care.

* Assumed responsibility for maintaining staffing budget demands while responding to widely fluctuating patient acuity and census.

* Participated in Nursing Department committees and task forces including the Acuity Steering Committee, Medication Process Task Force, Procedure Committee and Quality Assurance Committee.

* Functioned as liaison between Inpatient Psychiatry Services and Pharmacy.

* Monitored patient medication delivery as part of hospital quality assurance monitoring program.

* Consulted with architect and various hospital personnel to plan a psychiatric unit in a new facility and assisted with planning and coordinating Inpatient Psychiatry Services move to a new facility.

* Assisted with JCAHO reviews.

Clinical

* Provided initial and ongoing clinical review and authorization of services for all capitated clients.

* Conducted intake assessments on all inpatient psychiatry referrals.

* In-serviced and implemented a new multidisciplinary treatment plan.

* Counseled, supported and instructed psychiatric patients undergoing diagnostic evaluation and treatment on an acute psychiatric unit.

* Assessed, delivered and evaluated care provided to critically ill patients in an intensive care unit.

* Utilized sophisticated equipment in the evaluation and treatment of critically ill patients.

* Participated in multidisciplinary team approach to the development and evaluation of plans of care in the gerontological setting.

* Demonstrated clinical competence through use of the nursing process in medical-surgical nursing.

WORK HISTORY:

1/17 - present	Department of Medicine Dartmouth-Hitchcock Clinic Position: Interim Practice Manager Weight and Wellness Center and Sleep Medicine Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
10/16 - 1/17	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Sr. Practice Manager
7/16 - 10/16	Department of Psychiatry Dartmouth-Hitchcock Clinic Position: Practice Manager
7/01 - 6/16	Dartmouth-Hitchcock Psychiatric Associates, Department of Psychiatry, Geisel School of Medicine at Dartmouth Position: Administrative Director
7/98 - 6/01	Dartmouth Hitchcock Behavioral Healthcare Position: Care Management Coordinator
10/97 - 7/98	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
10/95 - 10/97	Dartmouth-Hitchcock Medical Center Position: Clinical Coordinator Inpatient Psychiatry Services Responsible for the management of Access Services, Psychiatry-Medicine Unit, and General Psychiatry Unit
7/93 - 9/95	Dartmouth-Hitchcock Medical Center Position: Coordinator Inpatient Psychiatry Access Services
9/89 - 6/93	Dartmouth-Hitchcock Medical Center

	Position: Clinical Coordinator Psychiatry-Medicine Unit/Short Term Unit
4/83 - 9/89	Dartmouth-Hitchcock Medical Center Position: Assistant Head Nurse General Psychiatry Unit Acting Head Nurse 11/87 - 7/88
5/81 - 4/83	Dartmouth-Hitchcock Medical Center Position: Staff Nurse General Psychiatry Unit
5/80 - 4/81	Hanover Terrace Health Care Position: Charge Nurse Skilled Care Unit
6/78 - 12/79	Dartmouth-Hitchcock Medical Center Position: Staff Nurse Intensive Care Unit
1/77 - 3/78	Frederick Memorial Hospital Position: Staff Nurse Medical-Surgical Unit
7/71 - 8/72	Dr. Herbert Glick Position: Medical Assistant Pediatric Office

EDUCATION:

1972 -1976	University of Maryland Bachelor of Science in Nursing Sigma Theta Tau and Phi Kapa Phi honor societies
1986	University of New Hampshire Course work toward Masters in Nursing Administration

LICENSURE:

Registered Nurse
License No. 021135-21
State of New Hampshire

COMMITTEE MEMBERSHIP:

Corporate Compliance Committee, Coordinator
Dartmouth Hitchcock Psychiatric Associates
Quality Improvement Committee
Dartmouth Hitchcock Psychiatric Associates

SELECTED CONTINUING EDUCATION:

2015	Ethical Dilemmas in Adult Services
	Geriatric Trauma
2014	Optimizing Our Interactions with Families with Substance Use Disorders
2013	Dartmouth-Hitchcock Value Institute - Intermediate Online Curriculum (Yellow belt)
	Treating People with Alzheimer's disease - Working with Preserved Abilities
	Dementia Care: Approaches to Managing Challenging Behaviors
	Issues in Geriatric Health Series-Frailty in the Older Adult
2012	Elder Abuse and Self Neglect: Building Bridges to Address Ethical Dilemmas
	Geriatric Mental Health Conference
2011	Jeanne Anderson Alzheimer's Conference
2010	Geriatric Update 2010
	Interdisciplinary Geriatric Palliative Care Conference
2009	Aging and Nutrition
	Ethical Issues in the Care of Older Adults
2008	Executive Education Series Tuck Business School, Dartmouth College

2006	Professional Medical Coding Lebanon College
1998	New England Healthcare Assembly Case Management Certificate Program

TERI BISHOP LAROCK

[redacted]

LICENSE #
New Hampshire LICSW # 1847
Massachusetts LICSW #1021146
Vermont LICSW # 0890055650

EDUCATION

Boston University School of Social Work, Boston, MA	MSW, May 1990
University of Vermont, Burlington, VT	BA Psychology, May, 1988

PROFESSIONAL EXPERIENCE

Dartmouth Hitchcock Medical Center (DHMC)
Lebanon, New Hampshire

Clinical Director; Moms in Recovery; Psychiatry 2018-Present

*Management of a team of clinicians providing psychosocial assessment, counseling and treatment to pregnant and parenting women in an integrated care clinical setting.

* Facilitation of and assistance with development, design and training of agency programs.

*Clinical supervision to candidates for MSW licensure. Clinical supervision of peer support recovery coaches in Emergency Department setting.

Behavioral Health Clinician; Moms in Recovery; Psychiatry 2016-2018

*Evaluation, diagnosis and treatment of women with substance use disorder and co-occurring mental health diagnoses such as anxiety and mood disorders in an integrated care clinical setting.

*Establishment and documentation of treatment goals utilizing appropriate psychotherapy including group and individual, trauma sensitive cognitive behavioral therapy, crisis intervention and supportive cognitive therapy. Trained facilitator of Circle of Security Parenting curriculum.

*Communication and collaboration with interdisciplinary team and community partners to assure proactive and successful integrated care with a high risk population facing significant resource insecurities and marginalization.

Behavioral Health Clinician; Behavioral intervention Team; Psychiatry 2014-Present

*Comprehensive and targeted proactive primary mental health assessment and intervention with medically hospitalized patients experiencing mental health related symptoms. Timely follow-up and

targeted behavioral health interventions including cognitive behavioral therapy, motivational interviewing, guided visual imagery, crisis intervention and therapeutic supportive counseling.

*Development of strategies with the healthcare team to advocate for patients psychiatric and behavioral needs. Work with team to negotiate complex systems to remove barriers and limitations in accessing appropriate disposition plans. Participation in complex care and ethics meetings. Consultation and professional support to interdisciplinary team members. Education of mental health education with medical staff. Teaching with and support of primary MSWs on units regarding behavioral and mental health patient care and interventions.

Continuing Care Manager: Child Advocacy and Protection Program; Pediatrics 2007-2017

*Perform comprehensive assessment with families of children suspected to be victims of neglect, physical, sexual abuse and intimate partner violence. Evaluation of health and functional status, cognitive capability, support systems, biopsychosocial functioning, finances and health/wellness status

*Development and implementation of plan of care to include family strengths and challenges. Supportive trauma informed and trauma focused counseling with family. Collaboration with involved child protection, law enforcement and mental health agencies. Testimony in court as needed. Non-offender support group.

*Teaching with pediatric residents, nursing and allied health service staff about trauma informed mental health assessment, diagnosis and psychosocial care of at risk children and families. Supervision of MSW interns from Boston University, University of Vermont, University of New Hampshire, and Simmons College

Pediatric Nephrology Social Worker 2012-Present

*Coordinated caseload of children and families diagnosed and coping with kidney disease as part of a multidisciplinary team. Case management and collaboration with community resources including Partners in Health, Children with Special Health Needs, Team Impact, Camp Sunshine and primary care offices

Pediatric Social Worker 2006-2007

*Assessment, supportive counseling and referrals to and collaboration with community agencies for families of children admitted to pediatric and pediatric intensive care units for treatment of illness and injury. Crisis intervention and bereavement counseling. Member of interdisciplinary care team. Psychosocial and mental health education with Dartmouth medical students, residents and nursing.

Per Diem Social Worker 2004-2006

Clinical social work coverage on adult and pediatric units throughout the 400 bed medical center. Assessment and brief intervention with individuals and families. Facilitation of processes including

guardianship, placement, and residential settings. Coordination of care with existing resources and referrals to community supports.

Community Health Link/University of Massachusetts (aka The Herbert Lipton Center) Fitchburg, MA

Clinical Social Worker 1998-2004

Provided both long term and brief individual weekly therapy to clients with mental health and complex psychosocial challenges in a multicultural, low socioeconomic clinical setting. Modalities of counseling included cognitive behavioral therapy, crisis intervention, motivational interviewing and supportive counseling. Individual counseling with women transitioning from Framingham State Prison system to home/community environment who were working with child protection to re-establish custody of their children. Development and implementation of treatment plans and collaboration with community agencies.

Clinical Social Worker 2002-2004

School based counseling at Leominster High School, a large suburban high school, via Community Health Link. Assessment and crisis intervention with adolescents and families. Wrote comprehensive evaluations and developed treatment plans for adolescents engaging in self harming behaviors and substance use. Collaboration and referral to community based services. Member of interdisciplinary team working with Department of Youth Services, Department of Social Services and Department of Mental Health.

Boston Children's Hospital
Boston, MA
Clinical Social Worker Emergency Department 1995-1998

*Child abuse and neglect assessment, collaboration with Department of Social Services and other collateral agencies. Crisis intervention counseling and intervention. Referrals to local community resources and health centers.

Clinical Social Worker 1991-1995

*Psychosocial assessment, crisis intervention, brief treatment and case management with families on three inpatient medical and surgical units. Individual, family and group counseling. Collaboration with interdisciplinary team and community resources.

*Supervision responsibilities; summer staff social work position, Boston University, Simmons College and Boston College MSW students. Emergency room coverage. Co-leader of weekly Parent Support Group and Adolescent Cystic Fibrosis Group.

Waltham Weston Hospital and Medical Center
Waltham, MA
Clinical Social Worker 1990-1991

*Assessment of individual and family psychosocial situations on Birthing/GYN, Pediatric and Medical/Surgical adult units. Development of Family/Child High Risk Criteria. Provided crisis intervention, short term and group therapy. Rotating Emergency Department coverage. Facilitator of community based Gulf War Family Support Group.

Boston Children's Hospital
Boston, MA
Social Work Intern 1989-1990

Provided individual and group counseling to hospitalized children and families. Referrals to relevant community counseling agencies, support groups, shelters, IPV resources and economic agencies. Collaboration with hospital based Child Protective Team and Massachusetts Child Protection.

Mary Curley Middle School
Jamaica Plain, MA
Social Work Intern 1988-1989
Provided individual counseling and brief treatment to teenage adolescents in an urban middle school environment. Facilitation of multicultural seventh grade girls Peer Support and Leadership Groups with focus on societal challenges of poverty, oppression and ethnic difference. Co-facilitator of drug, alcohol and sexual health education psych-educational groups.

Tonya L. Suarez, MSW, LICSW

[redacted]

Education

Master of Social Work, May 2012
University of New Hampshire, Durham New Hampshire

Bachelor of Arts, Psychology, May 2002
Saint Anselm College, Manchester New Hampshire

LICSW NH Board of Mental Health, September 2017

Professional Experience

Addiction Treatment Programs at Dartmouth Hitchcock Medical Center
(January 2018-present time)
Lebanon, New Hampshire
Clinician

- Conduct substance abuse evaluations/assessments and provide treatment recommendations
- Provide individual and group therapy
- Work with patient and treatment providers to determine treatment plan and goals within Outpatient Program, Intensive Outpatient Program, and Maintenance Recovery Programs.
- Communicate with area agencies to support ongoing needs of patients

West Central Behavioral Health Center (March 2015-present time, part time)
Lebanon, New Hampshire
Child Clinician

- Provide ongoing therapy to children ages 5-18 within a community mental health setting.
- Engage in assessment and diagnosis.
- Create individualized treatment plan to determine therapeutic goals.
- Work with family to develop a collaborative treatment plan for youth.
- Engage in ongoing review of treatment and goals to determine level of therapeutic care.
- Communicate with schools and other facilities regarding youth's needs and progress.

Child Advocacy Center of Grafton and Sullivan Counties at Dartmouth Hitchcock Medical Center (January 2014-January 2018) *Lebanon, New Hampshire*
CAC Resource Coordinator/Forensic Interviewer Specialist

- Conduct Forensic Interviews of children of suspected sexual abuse, physical abuse, and witness to violence.
- Facilitate a multi-disciplinary team to plan, coordinate services, and interventions where there are concerns for abuse.
- Crisis Intervention and assessment
- Case coordination for the victims and their families.
- Referrals for follow up services including mental health and medical evaluations
- Community outreach and prevention.
- Supervise and support bachelor level internships.

Children's Hospital at Dartmouth Hitchcock Medical Center (June 2012-May 2014) *Lebanon , New Hampshire*
Pediatric Clinical Social Worker

- Provide ongoing supportive counseling to families during the hospitalization of a child.
- Complete thorough psychosocial assessments to assess for resources and clinical/therapeutic needs.
- Provide resource and referral information.
- Crisis intervention and ongoing therapeutic support to families with children diagnosed with chronic illness, trauma events, and scheduled procedures. Provide grief and loss counseling in the setting of the loss of a child.
- Facilitate adult support group for parents with children diagnosed with diabetes.
- Work within a multi-disciplinary team of providers. Provided ongoing education to team members regarding the impact of psychosocial dynamics on the family and child.
- Participated in Pediatric Schwartz Rounds, grief and loss education, and David's House Guest Support Committee.
- Work with community providers/area agencies to connect families to ongoing support services.

Dartmouth Hitchcock Medical Center (August 2011-May 2012)
Lebanon, New Hampshire
Advanced MSW Clinical Intern

- A dual internship working with the pediatric hematology/oncology team and the Child Advocacy and Protection Program.
- Conducted psychosocial assessments to assess for resources and clinical needs of family and patient.
- Worked within the inpatient and outpatient setting providing ongoing clinical support to families.
- Crisis Intervention, supportive counseling, and grief and loss counseling.

Sununu Youth Services Center (September 2009-May 2010)
Manchester, NH
MSW Clinical Intern

- Provided ongoing therapeutic counseling sessions for adolescent males committed to a locked juvenile correctional facility.
- Conducted psychosocial assessments of newly committed residents and present to a classification board to determine the treatment program.
- Assist with the development of treatment plans for committed residents.
- Observe/co-facilitate family therapy sessions.
- Co-facilitate weekly mindfulness group.
- Facilitate a weekly therapeutic group with committed residents.

Child Advocacy Center of Grafton and Sullivan Counties at Dartmouth Hitchcock Medical Center (March 2009-May 2012)
Lebanon, NH
CAC Resource Coordinator

- Conduct Forensic Interviews of children of suspected sexual abuse, physical abuse, and witness to violence.
- Work within a multi-disciplinary team to plan and coordinate services and interventions where there are concerns for abuse.
- Case coordination for the victims and their families.
- Referrals for follow up services including mental health and medical evaluations
- Community outreach and prevention.

Division for Children, Youth, and Families (May 2005-February 2009)
Claremont and Concord, NH
Child Protective Service Worker

- Investigated reports of child abuse and neglect.
- Interviewed all persons involved and determine risk of child and course of action.
- Organization and Documentation of investigation through Bridges Software System and paper file.
- Participated in court proceedings when necessary including direct testimony, preparing supporting evidence, and court reports.

Lebanon School District (February 2005-June 2005 part time)
Lebanon, NH
Substitute Teacher

- Assisted school district when a substitute teacher was needed.
- Successfully handled children from ages 5-18 in the classroom.

Lebanon High School (Spring 2005, Spring 2006)
Lebanon, NH
Junior Varsity Women's Lacrosse Coach

- Coached a team of 9th and 10th grade girls.

- Utilized organizational skills to create a fun and productive learning environment.
- Facilitated drills in which the girls could learn and improve upon their skills.

Division of Youth and Family Services (August 2003-December 2004)
East Orange, NJ
Family Service Specialist

- Responsible for a high case load of high risk families.
- Investigated child abuse and neglect referrals.
- Utilized resources to make informed decisions in the best interest of the child/children.
- Assisted and arranged necessary services for family stabilization.
- Successfully organized and documented events of each case.

Easter Seals Girls Group Home (July 2002-July 2003)
Manchester, NH
Residential Instructor

- Worked with emotionally and mentally handicapped females ages 12-21.
- Assisted in the creation and implementation of individualized treatment plans.
- Assisted with daily living skills and coping skills, as well as role modeling these behaviors.

Robert B. Jolicoeur School (December 2002-July 2003 part time)
Manchester, NH
Teachers Aid

- Worked with emotionally and mentally handicapped youths ages 12-21.
- Assisted in classroom tasks.
- Successfully implemented treatment plans into classroom routines.

Specialized Trainings

Forensic Interview Training (April 2006)
Extended Forensic Interview Training (Summer 2011)
Forensic Interview Testimony (Fall 2011)
Interviewing Children with Disabilities (Fall 2016)
Trauma Focused Cognitive Behavioral Therapy (April 2015)
Cognitive Behavioral Therapy (November 2015)

Dartmouth-Hitchcock Health
Mary Hitchcock Memorial Hospital

Key Personnel

FY'21 Integrated Medication Assisted Treatment (IMAT)

Name	Job Title	Salary*	% Paid from this Contract	Amount Paid + from this Contract
Julia Frew	Medical Director (MD)	$251,222	20%	$33,496
Daisy Goodman	Women's Health Director	$132,163	10%	$8,811
Alena Shoemaker	Integrated Primary Care MD	$225,000	20%	$30,000
Teri Larock	LICSW	$94,723	75%	$47,362
Lucy Pilcher	LICSW	$74,318	100%	$49,546
Tonya Suarez	LICSW	$76,877	30%	$15,375
Martha Catalona	Program Manager	$108,825	50%	$36,275

* Salary column reflects annual salary amount as of FY'21
+ Amount paid column reflects FY'21 Spoke/MAT Program contract term of 9 months

FY'22 Integrated Medication Assisted Treatment (IMAT)

Name	Job Title	Salary*	% Paid from this Contract	Amount Paid + from this Contract
Julia Frew	Medical Director (MD)	$258,759	10%	$6,469
Daisy Goodman	Women's Health Director	$136,128	10%	$3,403
Alena Shoemaker	Integrated Primary Care MD	$231,750	10%	$5,794
Teri Larock	LICSW	$97,565	75%	$18,293
Lucy Pilcher	LICSW	$76,548	100%	$19,137
Tonya Suarez	LICSW	$79,183	10%	$1,979
Martha Catalona	Program Manager	$112,090	50%	$14,011

* Salary column reflects projected annual salary amount as of FY'22
+ Amount paid column reflects FY'22 Spoke/MAT Program contract term of 3 months

16A mac

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9544 1-800-852-3345 Ext. 9544
Fax: 603-271-4332 TDD Access: 1-800-735-2964 www.dhhs.nh.gov

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

September 19, 2019

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 for Behavioral Health, to **retroactively** exercise a renewal option and amend an existing agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, to provide integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder by increasing the price limitation by $1,499,970 from $2,755,443 to $4,255,413 and by extending the completion date from June 30, 2019 to September 30, 2020, retroactive to June 30, 2019, effective upon Governor and Executive Council approval. 100% Federal Funds.

This agreement was originally approved by the Governor and Executive Council on January 24, 2018 (Item #8 Vote 5-0).

Funds to support this request are anticipated to be available in the following account(s) for State Fiscal Years 2020 and 2021 upon the availability and continued appropriation of funds in the future operating budget, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office, if needed and justified.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

SFY	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2018	102-500731	Contracts for Program Services	92052559	$ 862,630	$0	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813	$0	$1,892,813
2020	102-500731	Contracts for Program Services	92052559	$0	$600,000	$600,000
			Subtotal	***$2,755,443***	***$600,000***	***$3,355,443***

05-95-92-920510-70400000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, STATE OPIOID RESPONSE GRANT

SFY	Class/ Account	Class Title	Job Number	Current Modified Budget	Increase/ (Decrease)	Revised Modified Budget
2020	102-500731	Contracts for Program Services	92057040	$ 0	$603,472	$ 603,472
2021	102-500731	Contracts for Program Services	92057040	$0	$296,498	$296,498
			Subtotal	***$0***	***$899,970***	***$899,970***
			Total	**$2,755,443**	**$1,499,970**	**$4,255,413**

EXPLANATION

This request is **retroactive** because additional time was required to address invoice matters that needed to be resolved prior to executing this amendment. The Department also held discussions with the Contractor during this time to identify necessary changes to the scope of work, described below, that will allow the Contractor to achieve desired positive outcomes for the targeted population and service areas.

This purpose of this request is to allow the Contractor to continue to serve their target population and geographic areas without interruption, while revising the project to accurately reflect changes to the scope of services by reducing the number of service sites from eight (8) to six (6). Through the initial agreement, the Contractor collaborated with the Department to identify and approach agencies in geographic areas of need and was able to reach agreement with six (6) of the eight (8) sites proposed and offer services at the following locations: Dartmouth Hitchcock - Keene, Dartmouth Hitchcock - Manchester, Dartmouth Hitchcock - Nashua, Coos County Family Health, Goodwin Community Health - Dover, and Darthmoth Hitchcock - Lebanon. They were unable to reach agreement with two (2) additional providers who were not interested in expanding their services at this time. Changes reflected in this amendment will allow the Contractor to continue to achieve positive outcomes for the women and children served at the six (6) existing sites.

The Contractor will continue to provide integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. MAT services will be integrated with prenatal and postpartum care, and provided with parenting support and education at six (6) sites across New Hampshire, including sites in the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

Approximately 260 individuals served from July 1, 2019 through September 30, 2020.

The original agreement, included language in Exhibit C-1, Revisions to General Provisions, Section 3, Extension, that allows the Department to renew the contract for up to two (2) years, subject to the continued availability of funding, satisfactory performance of service, parties' written authorization and approval from the Governor and Executive Council. The Department is in agreement with renewing services for one (1) year and three (3) months of the two (2) years at this time.

The Contractor delivers services through both a Perinatal Addiction Treatment Program in Lebanon, NH that is integrated with obstetrics/gynecology and pediatric care on-site and at seven (7) other sites which are obstetrical/gynecological practices that are enhanced with Medication Assisted Treatment services and pediatric care.

The State of New Hampshire was awarded funding authorized through the 21st Century CURES Act by the Substance Abuse and Mental Health Services Administration which is overseeing the process for states to receive federal funding through the State Targeted Response to the Opioid Crisis Grants Program. New Hampshire's application is a joint effort by several state agencies and proposes to use evidence-based methods to expand treatment, recovery and prevention services to targeted populations. These critical funds will strengthen established programs that have had a positive impact on the opioid crisis as well as expanding the capacity for programs that have shown promise in helping individuals battling a substance misuse issue and combatting the epidemic in New Hampshire.

In 2018, the State of New Hampshire experienced four hundred seventy-one (471) deaths from drug overdoses. At present, the State is experiencing an increase in the need for population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers develop integration of services, approaches to meet individual client needs, and approaches to maximize State and Federal dollars to meet the public's demand for these specific services. The services provided by the Contractor will be comprehensive and focused not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

Mary Hitchcock Memorial Hospital's effectiveness in delivering services will be measured through monitoring of the following aggregate performance measures on an annual basis:

- Fifty percent (50%) of women referred to the program, who consent to treatment and qualify based on clinical evaluation, will enter opioid use disorder (OUD) treatment as reported by the Contractor.
- Seventy-five percent (75%) of women identified by American Society of Addiction Medicine (ASAM) criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.
- Five percent (5%) decline in neonatal abstinence syndrome (NAS) rates of infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed, as reported by the Contractor.
- Five percent (5%) decrease in positive urine drug screens for illicit substances for pregnant women served in this program as reported by the Contractor.
- Five percent (5%) decrease in reports to Division for Children, Youth, and Family (DCYF) of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as reported by the Contractor and through the use of collected hospital and DCYF data.

Should the Governor and Executive Council not authorize this request, pregnant and postpartum women in New Hampshire diagnosed with opioid use disorder may not receive the support necessary to overcome their addiction which could negatively impact their health and the health of their newborn child(ren).

Area served: Statewide

Source of Funds: 100% Federal Funds. CFDA#93.788 /FAIN# TI080246 and FAIN # TI081685.

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

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

September 23, 2019

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a retroactive contract amendment with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047A.

This is a request to enter into a retroactive contract amendment with Mary Hitchcock Memorial Hospital to provide integrated obstetric, primary care, pediatric, and medication assisted treatment for pregnant and postpartum women with substance use disorder (SUD). This will also include utilizing the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions.

The funding amount for this amendment is $1,499,970.00, increasing the current contract from $2,755,443.00 to $4,255.413.00, retroactive to June 30, 2019 and by extending the completion date from June 30, 2019 to September 30, 2020, effective upon Governor and Executive Council approval.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet FOR

Denis Goulet

DG/kaf/ck
DoIT #2018-047A
cc: Bruce Smith, IT Manager, DoIT

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women Contract

This 1st Amendment to the Integrated Medication Assisted Treatment for Pregnant and Postpartum Women contract (hereinafter referred to as "Amendment #1") is by and between the State of New Hampshire, Department of Health and Human Services (hereinafter referred to as the "State" or "Department") and Mary Hitchcock Memorial Hospital, (hereinafter referred to as "the Contractor"), a nonprofit corporation with a place of business at Dartmouth-Hitchcock, One Medical Center Drive, Lebanon, NH 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on January 24, 2018, (Item #8), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract as amended and in consideration of certain sums specified; and

WHEREAS, the State and the Contractor have agreed to make changes to the scope of work, payment schedules or terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, and Exhibit C-1, Revisions to General Provisions, Paragraph 3, the Contract may be amended upon written agreement of the parties and approval from the Governor and Executive Council; and

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

WHEREAS, all terms and conditions of the Contract and prior amendments not inconsistent with this Amendment #1 remain in full force and effect; and

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

1. Form P-37 General Provisions, Block 1.7, Completion Date, to read:

   September 30, 2020.

2. Form P-37, General Provisions, Block 1.8, Price Limitation, to read:

   $4,255,413.

3. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Nathan D. White, Director.

4. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read:

   603-271-9631.

5. Form P-37, General Provisions, Section 14, Insurance, Subsection 14.2, to read:

   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.

6. Form P-37, General Provisions, Section 15, Workers' Compensation, Subsection 15.2, to read:

   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 as required in N.H. RSA chapter 281-A. Contractor shall furnish the Contracting Officer identified in block 1.9, or his/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.

7. Delete Exhibit A, Scope of Services in its entirety and replace with Exhibit A - Amendment #1, Scope of Services.
8. Add Exhibit B-3, Amendment #1.
9. Add Exhibit B-4, Amendment #1.
10. Delete Exhibit K, DHHS Information Security Requirements, dated 032917, and replace with Exhibit K, DHHS Information Security Requirements, v4, dated October 2018.

New Hampshire Department of Health and Human Services
Integrated Medication Assisted Treatment for
Pregnant and Postpartum Women

This amendment shall be retroactively effective to June 30, 2019, upon the date of Governor and Executive Council approval.

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

State of New Hampshire
Department of Health and Human Services

9/10/19
Date

Name: Katja S. Fox
Title: Director

Mary Hitchcock Memorial Hospital

9/6/19
Date

Name: Edward J. Merrens
Title: Chief Clinical Officer

Acknowledgement of ~~Contractor's~~ Ed Merrens signature:

State of New Hampshire County of Grafton on September 6, 2019 before the undersigned officer, personally appeared the person identified directly above, or satisfactorily proven to be the person whose name is signed above, and acknowledged that s/he executed this document in the capacity indicated above.

Signature of Notary Public or Justice of the Peace

Laura Rondeau, Notary Public
Name and Title of Notary or Justice of the Peace

LAURA K. RONDEAU
STATE OF NEW HAMPSHIRE
NOTARY PUBLIC
MY COMMISSION EXPIRES APRIL 19, 2022

My Commission Expires: April 19, 2022

New Hampshire Department of Health and Human Services
Integrated Medication Assisted Treatment for
Pregnant and Postpartum Women

The preceding Amendment, having been reviewed by this office, is approved as to form, substance, and execution.

OFFICE OF THE ATTORNEY GENERAL

9/13/19
Date

Name: CATHERINE PINOS
Title: Attorney

I hereby certify that the foregoing Amendment was approved by the Governor and Executive Council of the State of New Hampshire at the Meeting on: _____ (date of meeting)

OFFICE OF THE SECRETARY OF STATE

Date

Name:
Title:

Scope of Services

1. Provisions Applicable to All Services

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

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Work

2.1. The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders, integrated with prenatal and postpartum care, and provide parenting support and education for parents at six (6) sites across the State of New Hampshire, including one (1) in Coos County.

2.2. The Contractor shall deliver the required services in Lebanon through the Dartmouth Hitchcock (D-H) Moms in Recovery Program a comprehensive addiction treatment service with integrated obstetrical/gynecological (OB/Gyn) services and pediatric care offered on-site.

2.3. The Contractor shall ensure delivery of the required services at the five (5) other sites where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services and pediatric support.

2.4. The Contractor shall provide project management, program consultation, and clinical consultation through their D-H Center for Addiction Recovery in Pregnancy and Parenting team to each site.

2.5. The Contractor shall provide services at all six (6) sites including, but not limited to:

2.5.1. On-site family support for children.

2.5.2. Peer recovery coaches.

2.5.3. Resource/Employment specialists.

2.5.4. Case management/Care coordination.

2.5.5. Parenting education groups.

2.5.6. Health education.

2.5.7. Social supports including, but not limited to access and/or referrals to food, housing, and transportation services.

2.6. The Contractor shall employ a licensed behavioral health clinician whose responsibilities shall include, but not be limited to:

2.6.1. Providing necessary supervision at each site.

2.6.2. Supporting and mentoring for weekly MAT visits.

2.6.3. Supporting and mentoring of the leadership providing group therapy for participating women.

2.6.4. Collaborating with each site to identify or develop behavioral health resources in the local community.

2.7. The Contractor shall ensure each site:

2.7.1. Identifies a minimum of one (1) waivered provider to prescribe buprenorphine.

2.7.2. Provides consultative phone calls over a twelve (12)-month period in a frequency determined necessary by the providers and the Contractor.

2.8. The Contractor shall provide services through the D-H Moms in Recovery Program which include, but are not limited to:

2.8.1. Collaborating with the Family Resource Centers, whose services include, but are not limited to:

2.8.1.1. Home visiting.

2.8.1.2. Lactation support.

2.8.1.3. Case management.

2.8.2. Providing parent education groups to program participants on a regular basis which integrate the parenting education curriculum with addiction treatment, so that participants have the opportunity to learn about the impact of substance use on family functioning and healthy child development.

2.8.3. Providing educational sessions to all pregnancy groups which include, but are not limited to "The Period of Purple Crying," safe sleep practices, and car seat safety and are integrated with newborn nursery and outpatient pediatric follow up.

2.8.4. Collaborating with Continuum of Care Coordinators as part of Region 1 Integrated Delivery Network (IDN).

2.8.5. Participating in the Boyle Program, which co-sponsors and facilitates the Child Focus Forum, a bi-monthly collaborative of medical, governmental and community agencies serving parents and children.

2.8.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction.

2.8.7. Sponsoring co-location of resources such as a food pantry, infant books, and diaper bank through active partnerships with community agencies such as The Upper Valley Haven and The Family Place.

2.9. The Contractor shall ensure patient-centered, effective, integrated care and attention to overdose prevention by employing educational materials which include, but are not limited to:

2.9.1. Center for Disease Control (CDC) opioid prescribing guidelines.

2.9.2. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Opioid Overdose Prevention Toolkit.

2.9.3. State-published Guidance Document on Best Practices: Key Components for Delivering Community Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire.

2.9.4. Care guidelines for OB/GYN providers and delivery hospitals developed by the Northern New England Perinatal Quality Improvement Network (NNEPQIN).

2.10. The Contractor shall provide interim OUD treatment services when the needed treatment services are not available to the participant within forty-eight (48) hours of referral.

2.11. The Contractor shall provide OUD treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model. (More information can be found at http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm.)

2.12. The Contractor shall ensure that participants are able to easily transition between levels of care within a group of services which includes, but is not limited to:

2.12.1. Working with the Continuum of Care Facilitator(s) in the development of a resiliency and recovery oriented system of care (RROSC) in the region(s).

2.12.2. Participating in the Regional Continuum of Care Workgroup(s).

2.12.3. Participating in the Integrated Delivery Network(s) (IDNs).

2.12.4. Working with the Doorways system.

2.13. The Contractor shall ensure ongoing communication and care coordination with entities involved in the participants' care including child protective services, treatment providers, home visiting services, and pediatric providers.

2.14. The Contractor shall actively participate in the Regional Continuum of Care and IDN Region 1, and maintain good relationships with relevant community partners.

2.15. The Contractor shall assist enhanced sites with hiring for any vacant position for a Recovery Coach to help participants locate community resources including, but not limited to local recovery centers, peer support meetings, and transitional housing.

2.16. The Contractor shall assist enhanced sites with collaborating with their local/regional Continuum of Care Facilitators and leaders of their regional Integrated Delivery Networks to ensure alignment and coordination across these service networks.

2.17. The Contractor shall collaborate with each enhanced site to modify workflows and electronic records processes to ensure screening and required data collection.

2.18. The Contractor shall modify the obstetrics office electronic health record (EHR) and clinical work flow to ensure required screening activities by OB staff and appropriate required data collection by care coordinators.

2.19. The Contractor shall utilize the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions and shall assess each enhanced site's use and support them to develop protocols to monitor the PDMP regularly.

2.20. The Contractor shall ensure that D-H Lebanon Addiction Treatment Program protocol for PDMP monitoring includes, but is not limited to, reviewing the PDMP at a patient's first visit and the day before each subsequent visit.

2.21. The Contractor shall develop and implement outreach activities, which may include marketing designed to engage pregnant women with an OUD in the community. The Contractor and Contractor's sites are not required to market themselves publicly as substance use disorder treatment centers. The Contractor shall:

2.21.1. Ensure that their staff at the Center for Addiction Recovery in Pregnancy and Parenting collaborate with the appropriate D-H department to develop appropriate materials and methods to promote the program throughout their service areas.

2.21.2. Collaborate with each implementing site to ensure marketing materials, if any, and outreach methods used, are consistent with the Contractor's standards and policies in its discretion.

2.21.3. Actively engage with referral networks in the service areas to increase awareness of the program with pregnant women with OUD and to enable the program to be utilized to its greatest capacity.

2.22. The Contractor shall maintain formal and effective partnerships with behavioral health, OUD specialty treatment and Recovery Support Services (RSS), and medical practitioners to meet the needs of the target population and the goals of MAT Expansion.

2.23. The Contractor shall ensure meaningful input of consumers in program assessment, planning, implementation, and improvement which includes, but is not limited to:

2.23.1. Using their Patient Advisory Board, which meets quarterly and is composed of participants in long-term recovery.

2.23.2. Engaging participants in all stages of recovery in the development of key program elements through focus groups and targeted interviews.

2.24. The Contractor shall ensure that treatment is provided in a child-friendly environment with childcare support available to participants which includes, but is not limited to:

2.24.1. Developmentally-appropriate childcare support as well as integration with pediatric and developmental services at all enhanced sites.

2.24.2. Co-located child "Play Time" where children engage in developmentally appropriate play while their mothers participate in group treatment and receive care in both Lebanon and Keene.

2.24.3. On-site well-child care at D-H Lebanon Moms in Recovery Program.

2.25. The Contractor shall ensure participants' transportation needs are met to maintain participant involvement in the program by utilizing a Resource Specialist whose duties related to transportation may include, but not be limited to:

2.25.1. Assisting participants to enroll in Medicaid transportation services.

2.25.2. Developing a network of support to help with transportation needs.

2.25.3. Identifying resources to help participants to obtain a valid driver's license or an affordable car loan.

2.25.4. Finding housing in close proximity to social services.

2.26. The Contractor shall use data to support quality improvement including, but not limited to:

2.26.1. Developing, disseminating, and implementing best practices for pregnant and parenting women with OUD.

2.26.2. Collecting data on participant demographics and more than thirty (30) key perinatal, neonatal, and treatment outcomes for all program participants, using a REDCap database designed for this purpose.

2.26.2.1. REDCap allows de-identified, participant-level data to be entered remotely by sites.

2.26.2.2. Data shall be entered for each participant from the time of entry into the program until three (3) months postpartum. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of pregnancy, at delivery, and at three (3) months postpartum.

2.26.2.3. Data shall be utilized for quality improvement purposes and program evaluation, as well as development of targeted services at all sites.

2.26.3. Collecting data on key measures identified by the Department and the Contractor's multidisciplinary stakeholder group and using the data to track performance.

2.26.3.1. The existing REDCap database shall be expanded as needed to include additional measures identified by the Department.

2.26.3.2. Site specific data shall be reviewed quarterly.

2.26.4. Reporting data to sites quarterly and addressing areas flagged for improvement both directly through discussion and process improvement at the individual practice level and through learning collaborative sessions with multiple practices.

2.26.5. Employing a research assistant to support sites with data entry challenges and ensure data quality.

2.26.6. Analyzing the data and promoting quality improvement efforts.

2.27. The Contractor shall maintain the infrastructure necessary to achieve the goals of MAT Expansion for the target population, to meet SAMHSA requirements, and to deliver effective medical care to pregnant and postpartum women with an OUD.

2.28. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects which include, but are not limited to:

2.28.1. Project-specific trainings.

2.28.2. Quarterly web-based discussions.

2.28.3. On-site Technical Assistance (TA) visits.

2.28.4. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

2.29. The Contractor shall participate in the development of a Safe Plan of Care with birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF) for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder, which includes, but is not limited to:

2.29.1. Employing a social worker to work with clients in this program.

2.29.2. Ensuring that planning and communication regarding the Safe Plan of Care will also involve other community agency supports including, but not limited to home visitation, WIC, housing, and other services central to recovery and parenting.

2.30. The Contractor shall establish formal agreements with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

2.30.1. The Contractor shall engage with the NNEPQIN learning collaborative, the organization that has developed policies and procedures to effectively address neonatal abstinence syndrome while supporting the mother's recovery.

2.31. The Contractor shall have billing capabilities which include, but are not limited to:

2.31.1. Enrolling with Medicaid and other third party payers.

2.31.2. Contracting with managed care organizations and insurance companies for MAT and delivery of prenatal care.

2.31.3. Having a proper understanding of the hierarchy of the billing process.

2.32. The Contractor shall assist the participant with obtaining either on-site or off-site RSS's including, but not limited to:

2.32.1. Transportation.

2.32.2. Childcare.

2.32.3. Peer support groups.

2.32.4. Recovery coach.

2.33. The Contractor shall use the New Hampshire Alcohol and Drug Treatment Locator (http://www.nhtreatment.org) and Doorways to identify specific services that are available by location, population, and payer to enable patient choice.

2.34. The Contractor shall establish agreements with specialty treatment organizations that can provide higher levels of OUD treatment and co-occurring mental health treatment.

2.35. The Contractor shall deliver parenting and personal development education using evidence-based curriculum including, but not limited to:

2.35.1. Marsha Linehan's Dialectical Behavior Therapy approach to treatment and Lisa Najavits' Seeking Safety curriculum to increase emotion regulation skills in participants to address Post-Traumatic Stress Disorder (PTSD) symptoms and decrease emotional vulnerability that could lead to relapse.

2.35.2. SAMHSA materials, 12-Step information, and other materials that the program has developed to increase participants' knowledge of the disease model of addiction and to enhance understanding of biological vulnerability and the progression of addiction.

2.35.3. Cognitive Behavioral Therapy (CBT), SAMSHA materials, 12-Step materials, and mindfulness-based stress reduction approaches to bolster relapse prevention strategies and improve resiliency.

2.35.4. Duluth Model Domestic Abuse Intervention Programs and Dialectical Behavior Therapy (DBT) to promote healthy relationships and decrease risk of interpersonal violence.

2.35.5. Circle of Security and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curricula to increase parent-child attachment and increase parents' knowledge of healthy child development.

2.36. The Contractor shall improve participants' access to a sober network of support and increased resiliency to relapse which includes, but is not limited to.

2.36.1. Utilizing an on-site Recovery Coach who participates in group therapy sessions and engages one-on-one with participants to provide additional support between sessions.

2.36.2. Inviting representatives from 12-Step groups and peer-run recovery groups on a regular basis to speak to participants.

2.37. The Contractor shall refer relapsing participants to residential or intensive outpatient care and provide support for accessing appropriate services including, but not limited to follow-up care after intensive treatment services are completed.

2.38. The Contractor shall provide parenting supports to participants including, but not limited to:

2.38.1. Parenting groups.

2.38.2. Childbirth education.

2.38.3. Safe sleep education.

2.39. The Contractor shall collaborate with other providers that offer services to pregnant women with an OUD including, but not limited to programs funded by the Cures Act resources for similar populations.

2.40. The Contractor shall ensure compliance with confidentiality requirements, which include, but are not limited to:

2.40.1. Applicable federal and state laws.

2.40.2. HIPAA Privacy Rule.

2.40.3. 42 C.F.R Part 2.

2.40.3.1. The D-H Moms in Recovery Program shall be required to follow 42 C.F.R Part 2 rules.

2.40.3.2. The OB/Gyn programs that will be enhanced with integrated addiction services are not required to follow 42 C.F.R. Part 2.

2.41. The Contractor shall participate in all evaluation activities associated with the funding opportunity, including national evaluations.

2.42. The Contractor shall submit an updated work plan to the Department for review and approval, which describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract.

2.43. The Contractor shall maintain policies and procedures and have regular required employee training (at least annually) in the areas of ethical conduct, confidentiality, compliance, cyber security, and conflict of interest.

3. Staffing

3.1. The Contractor shall meet the minimum MAT team staffing requirements to provide the Scope of Services which includes, but is not limited to at least one (1):

3.1.1. Waivered prescriber.

3.1.2. Masters Licensed Alcohol and Drug Counselor (MLADC) or behavioral health provider with addiction training.

3.1.3. Obstetrician or midwife.

3.1.4. Care coordinator.

3.1.5. Non-clinical/administrative staff.

3.2. The Contractor shall ensure that all unlicensed staff providing treatment, education, and/or recovery support services are under the direct supervision of a licensed supervisor.

3.3. The Contractor shall ensure that no licensed supervisor oversees more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.

3.4. The Contractor shall ensure that at least one Certified Recovery Support Worker (CRSW) is available for every fifty (50) participants or portion thereof.

3.5. The Contractor shall ensure that unlicensed staff providing clinical or recovery support services must hold a CRSW within six (6) months of hire or from the effective date of this contract, whichever is later.

4. Training

4.1. The Contractor shall make available initial and on-going training resources to all staff including, but not limited to buprenorphine waiver training for physicians, nurse practitioners, and physician assistants. The Contractor shall develop a plan for Department approval to train and engage appropriate staff.

4.2. The Contractor shall participate in training and technical assistant activities as directed by the Department including, but not limited to the Community of Practice for MAT which may include, but is not limited to:

4.2.1. Project-specific trainings.

4.2.2. Quarterly web-based discussions.

4.2.3. On-site technical assistance visits.

4.2.4. Ad hoc communication with expert consultants regarding MAT clinical care topics including, but not limited to:

4.2.4.1. HCV and HIV prevention.

4.2.4.2. Diversion risk mitigation.

4.2.4.3. Other relevant issues.

4.3. The Contractor shall train staff on relevant topics which may include, but are not limited to:

4.3.1. Integrated care.

4.3.2. Trauma-informed care.

4.3.3. MAT (e.g. prescriber training for buprenorphine).

4.3.4. Care coordination.

4.3.5. Trauma-informed wrap around care/RSS delivery best practices.

4.3.6. Evidence-Based Practices (EBPs) such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

4.3.7. Buprenorphine waiver trainings, available locally and at websites including, but not limited to:

4.3.7.1. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

4.3.7.2. https://www.asam.org/education/live-online-cme/buprenorphine-course

4.3.7.3. https://aanp.inreachce.com/Details?groupId=714cb0a9-73b2-4daf-8382-27cbdb70ef5a

4.3.8. Cognitive behavioral therapy, dialectical behavior therapy, motivational enhancement therapy, mindfulness, and relapse prevention.

4.4. The Contractor shall provide ongoing supervision for buprenorphine prescribers with access to consultation from experienced providers.

4.5. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall offer online training, CME/CNE events, and monthly learning collaboratives to each practice including, but not limited to:

4.5.1.1. Toolkit of training materials.

4.5.1.2. Weekly team meetings on day of clinic facilitated by the behavioral health clinician.

4.5.1.3. Monthly webinar learning collaboratives for all participating practices with rotating topics

4.5.1.4. Quarterly in-person gatherings for all participating practices, focused on relationship building and sharing of experiences, hosted at rotating locations to maximize participation.

4.5.1.5. Annual CME event aimed at all staff involved in this model of care.

4.6. The Contractor shall collaborate with the Doorways to provide assistance to all sites regarding training and logistics for the distribution of naloxone kits to patients and family members.

4.7. The Contractor shall assist practice staff in attending the following externally provided formal trainings:

4.7.1. CRSW training for prospective Recovery Coaches

4.7.2. Buprenorphine training for MDs/PAs/ARNPs

4.7.3. Smoking cessation training for any interested staff

4.7.4. Motivational Interviewing training for any interested staff

4.7.5. Additional trainings on trauma-informed care and other evidence based treatment strategies as indicated

5. Reporting

5.1. The Contractor shall gather, monitor, and submit participant data to the Department monthly. Participant data will be submitted in de-identified, aggregate form to the Department using a Department-approved method. The data being collected includes all data points required in the Treatment Episode Data for Admissions.

5.2. The Contractor shall report on federally-required data points specific to this funding opportunity quarterly and send the results in de-identified, aggregate form to the Department using a Department-approved method. The required data points include, but are not limited to:

5.2.1. Number of participants with OUD's:

5.2.1.1. In total.

5.2.1.2. Receiving integrated MAT with prenatal care.

5.2.1.3. Receiving care coordination/case management.

5.2.1.4. Receiving peer recovery support services.

5.2.1.5. Participating in parenting education programming.

5.2.1.6. Referred to or placed in recovery housing.

5.2.1.7. Referred to higher levels of care.

5.2.2. Number of providers in the program implementing MAT.

5.2.3. Number of OUD prevention and treatment providers trained by the program including, but not limited to Nurse Practitioners, Physician's Assistants, physicians, nurses, counselors, social workers, and case managers.

5.2.4. Numbers and rates of opioid overdose-related deaths within population served.

5.2.5. Number of children receiving childcare services by MAT program.

5.2.6. Number of infants in the program born with NAS not attributable to the mother taking prescribed MAT medications.

5.2.7. Number of referrals made to DCYF for substance-exposed infants not attributable to the mother taking prescribed MAT medications.

5.3. The Contractor shall require that all MAT-providing implementation sites report on the data points specified by the Department, utilizing a standardized protocol.

5.3.1. Each site will have exclusive access to protected health information for its own participants, and REDCap will be used to facilitate reporting of de-identified, aggregated data.

5.3.2. The Contractor shall provide a research assistant to help sites develop and implement appropriate site-specific data collection strategies to ensure compliance with reporting protocols.

5.4. The Contractor shall provide a final report to the Department within thirty (30) days of the termination of the contract which will include the following de-identified information based on the work plan progress, but shall not be limited to:

5.4.1. Policies and practices established.

5.4.2. Outreach activities.

5.4.3. Demographics of participants.

5.4.4. Outcome data (as directed by the Department).

5.4.5. Participant satisfaction.

5.4.6. Description of challenges encountered and action taken.

5.4.7. Other progress to date.

5.4.8. A sustainability plan to continue to provide MAT services to the target population beyond the completion date of the contract, subject to approval by the Department.

5.5. The Contractor shall provide a report to the Department regarding critical incidents and sentinel events which include, but are not limited to:

5.5.1. All critical incidents to the Department in writing as soon as possible and no more than 24 hours following the incident. The Contractor agrees that:

5.5.1.1. "Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to physical or mental health, safety, or well- being, including but not limited to:

5.5.1.1.1. Abuse;

5.5.1.1.2. Neglect;

5.5.1.1.3. Exploitation;

5.5.1.1.4. Rights violation;

5.5.1.1.5. Missing person;

5.5.1.1.6. Medical emergency;

5.5.1.1.7. Restraint; or

5.5.1.1.8. Medical error.

5.5.2. All contact with law enforcement to the Department in writing as soon as possible and no more than 24 hours following the incident.

5.5.3. All media contacts to the Department in writing as soon as possible and no more than 24 hours following the incident.

5.5.4. Sentinel events to the Department as follows:

5.5.4.1. Sentinel events shall be reported when they involve any individual who is receiving services under this contract.

5.5.4.2. Upon discovering the event, the Contractor shall provide immediate verbal notification of the event to the Department, which shall include:

5.5.4.2.1. The reporting individual's name, phone number, and agency/organization.

5.5.4.2.2. Name and date of birth (DOB) of the individual(s) involved in the event.

5.5.4.2.3. Location, date, and time of the event.

5.5.4.2.4. Description of the event, including what, when, where, how the event happened, and other relevant information, as well as the identification of any other individuals involved.

5.5.4.2.5. Whether the police were involved due to a crime or suspected crime.

5.5.4.2.6. The identification of any media that had reported the event.

5.5.4.3. Within 72 hours of the sentinel event, the Contractor shall submit a completed "Sentinel Event Reporting Form" (February 2017), available at https://www.dhhs.nh.gov/dcbcs/documents/reporting-form.pdf to the Department.

5.5.4.4. Additional information on the event that is discovered after filing the form in Section1.9.4.3. above shall be reported to the Department, in writing, as it becomes available or upon request of the Department; and

5.5.4.5. Submit additional information regarding Sections 5.5.4.1 through 5.5.4.4 above if required by the department; and

5.5.4.6. Report the event in Sections 5.5.4.1 through 5.5.4.4 above, as applicable, to other agencies as required by law.

6. Performance Measures

6.1. The following aggregate performance indicators are to be annually achieved and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Contractor.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.

6.1.3. The Contractor shall attempt to ensure that NAS rates of infants born to mothers served in this program not attributable to the mother taking MAT medications as prescribed will decline by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.4. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.5. The Contractor shall seek to help lower reports to DCYF of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed by five percent (5%) from SFY18 to SFY19. This performance measure will be reported by the Contractor and through the use of collected hospital and DCYF data.

6.2. Annually, the Contractor shall develop and submit to the Department, a corrective action plan for any performance measure that was not achieved.

New Hampshire Department of Health and Human Services

Contractor name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY20 (7/1/19-6/30/20)

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	508,874	149,523	[illegible]	-	-	-	508,874	149,523	[illegible]
2. Employee Benefits	141,341	41,413	[illegible]	-	-	-	141,341	41,413	[illegible]
3. Consultants	-	-	-	-	-	-	-	-	-
4. Equipment:	-	-	-	-	-	-	-	-	-
Rental	-	-	-	-	-	-	-	-	-
Repair and Maintenance	-	-	-	-	-	-	-	-	-
Purchase/Depreciation	-	-	-	-	-	-	-	-	-
5. Supplies:	-	-	-	-	-	-	-	-	-
Educational	-	-	-	-	-	-	-	-	-
Lab	-	-	-	-	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	-	-	-
Medical	9,360	2,742	12,102	-	-	-	9,360	2,742	12,102
Office	-	-	-	-	-	-	-	-	-
6. Travel	5,842	1,729	[illegible]	-	-	-	5,842	1,729	[illegible]
7. Occupancy	-	-	-	-	-	-	-	-	-
8. Current Expenses	-	-	-	-	-	-	-	-	-
Telephone	-	-	-	-	-	-	-	-	-
Postage	-	-	-	-	-	-	-	-	-
Subscriptions	-	-	-	-	-	-	-	-	-
Audit and Legal	-	-	-	-	-	-	-	-	-
Insurance	-	-	-	-	-	-	-	-	-
Board Expenses	-	-	-	-	-	-	-	-	-
9. Software	-	-	-	-	-	-	-	-	-
10. Marketing/Communications	-	-	-	-	-	-	-	-	-
11. Staff Education and Training	[illegible]	17,141	[illegible]	-	-	-	[illegible]	17,141	[illegible]
12. Subcontracts/Agreements	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
13. Other (specific details mandatory):	-	-	-	-	-	-	-	-	-
Patient Education Materials	4,811	1,419	[illegible]	-	-	-	4,811	1,419	[illegible]
	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-
TOTAL	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]

Indirect As A Percent of Direct [illegible]

Contractor Initials: [signature]

Date: 9/6/19

New Hampshire Department of Health and Human Services

Contractor name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: SFY21 (7/1/20-6/30/21)

Line Item	Total Program Cost: Direct (Incremental)	Total Program Cost: Indirect (Fixed)	Total Program Cost: Total	Contractor Share / Match: Direct (Incremental)	Contractor Share / Match: Indirect (Fixed)	Contractor Share / Match: Total	Funded by DHHS contract share: Direct (Incremental)	Funded by DHHS contract share: Indirect (Fixed)	Funded by DHHS contract share: Total
1. Total Salary/Wages	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
2. Employee Benefits	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
3. Consultants	-	-	-	-	-	-	-	-	-
4. Equipment:	-	-	-	-	-	-	-	-	-
Rental	-	-	-	-	-	-	-	-	-
Repair and Maintenance	-	-	-	-	-	-	-	-	-
Purchase/Depreciation	-	-	-	-	-	-	-	-	-
5. Supplies:	-	-	-	-	-	-	-	-	-
Educational	-	-	-	-	-	-	-	-	-
Lab	-	-	-	-	-	-	-	-	-
Pharmacy	-	-	-	-	-	-	-	-	-
Medical	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
Office	-	-	-	-	-	-	-	-	-
6. Travel	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
7. Occupancy	-	-	-	-	-	-	-	-	-
8. Current Expenses	-	-	-	-	-	-	-	-	-
Telephone	-	-	-	-	-	-	-	-	-
Postage	-	-	-	-	-	-	-	-	-
Subscriptions	-	-	-	-	-	-	-	-	-
Audit and Legal	-	-	-	-	-	-	-	-	-
Insurance	-	-	-	-	-	-	-	-	-
Board Expenses	-	-	-	-	-	-	-	-	-
9. Software	-	-	-	-	-	-	-	-	-
10. Marketing/Communications	-	-	-	-	-	-	-	-	-
11. Staff Education and Training	-	-	-	-	-	-	-	-	-
12. Subcontracts/Agreements	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
13. Other (specific details mandatory):	-	-	-	-	-	-	-	-	-
Patient Education Materials	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-
TOTAL	[illegible]	[illegible]	[illegible]	-	-	-	[illegible]	[illegible]	[illegible]
Indirect As A Percent of Direct		[illegible]							

Contractor Initials: DM

Date: 9/6/19

DEPARTMENT OF HEALTH & HUMAN SERVICES

Program Support Center
Financial Management Portfolio
Cost Allocation Services

26 Federal Plaza, Room 41-122
New York, NY 10278
PHONE: (212) 264-2069
EMAIL: CAS-NY@psc.hhs.gov

June 23, 2015

Ms. Tina E. Naimie
Vice President-Corporate Finance
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, New Hampshire 03756-0001

Dear Ms. Naimie:

A copy of an indirect cost rate agreement is being sent to you for signature. This agreement reflects an understanding reached between your organization and a member of my staff concerning the rate(s) that may be used to support your claim for indirect costs on grants and contracts with the Federal Government.

Please have the agreement signed by an authorized representative of your organization and return within ten business days of receipt. The signed agreement should be emailed to CAS-NY@psc.hhs.gov, while retaining a copy for your files. We will reproduce and distribute the agreement to the appropriate awarding organizations of the Federal Government for their use only when the signed agreement is returned.

An indirect cost proposal, together with the supporting information, is required to substantiate your claim for indirect costs under grants and contracts awarded by the Federal Government. Thus, your next proposal based on actual costs for the fiscal year ending 6/30/2017 is due in our office by 12/31/2017. Please submit your next proposal electronically via email to CAS-NY@psc.hhs.gov.

Sincerely,
Darryl W. Mayes -S

Darryl W. Mayes
Deputy Director
Cost Allocation Services

Enclosure

PLEASE SIGN AND RETURN THE NEGOTIATION AGREEMENT BY EMAIL

HOSPITALS RATE AGREEMENT

EIN: 1020222140A1

ORGANIZATION:
Dartmouth-Hitchcock
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, NH 03756-

DATE: 06/23/2015

FILING REF.: The preceding agreement was dated 03/27/2014

The rates approved in this agreement are for use on grants, contracts and other agreements with the Federal Government, subject to the conditions in Section III.

SECTION I: INDIRECT COST RATES

RATE TYPES: FIXED FINAL PROV. (PROVISIONAL) PRED. (PREDETERMINED)

EFFECTIVE PERIOD

TYPE	FROM	TO	RATE(%)	LOCATION	APPLICABLE TO
PRED.	07/01/2015	06/30/2018	29.30	On-Site	Other Sponsored Programs
PROV.	07/01/2018	06/30/2020	29.30	On-Site	Other Sponsored Programs

*BASE

Total direct costs excluding capital expenditures (buildings, individual items of equipment; alterations and renovations), that portion of each subaward in excess of $25,000; hospitalization and other fees associated with patient care whether the services are obtained from an owned, related or third party hospital or other medical facility; rental/maintenance of off-site activities; student tuition remission and student support costs (e,g., student aid, stipends, dependency allowances, scholarships, fellowships).

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 6/23/2015

SECTION II: SPECIAL REMARKS

TREATMENT OF FRINGE BENEFITS:

Fringe Benefits applicable to direct salaries and wages are treated as direct costs.

TREATMENT OF PAID ABSENCES

Vacation, holiday, sick leave pay and other paid absences are included in salaries and wages and are claimed on grants, contracts and other agreements as part of the normal cost for salaries and wages. Separate claims are not made for the cost of these paid absences.

Equipment means an article of nonexpendable, tangible person property having a useful life of more than two years, and an acquisition cost of $2,000 or more per unit.

Your next proposal based upon fiscal year ending 6/30/17 is due by 12/31/17.

ORGANIZATION: Dartmouth-Hitchcock

AGREEMENT DATE: 6/23/2015

SECTION III: GENERAL

A. LIMITATIONS:

The rates in this Agreement are subject to any statutory or administrative limitations and apply to a given grant, contract or other agreement only to the extent that funds are available. Acceptance of the rates is subject to the following conditions: (1) Only costs incurred by the organization were included in its indirect cost pool as finally accepted; such costs are legal obligations of the organization and are allowable under the governing cost principles; (2) The same costs that have been treated as indirect costs are not claimed as direct costs; (3) Similar types of costs have been accorded consistent accounting treatment; and (4) The information provided by the organization which was used to establish the rates is not later found to be materially incomplete or inaccurate by the Federal Government. In such situations the rate(s) would be subject to renegotiation at the discretion of the Federal Government.

B. ACCOUNTING CHANGES:

This Agreement is based on the accounting system purported by the organization to be in effect during the Agreement period. Changes to the method of accounting for costs which affect the amount of reimbursement resulting from the use of this Agreement require prior approval of the authorized representative of the cognizant agency. Such changes include, but are not limited to, changes in the charging of a particular type of cost from indirect to direct. Failure to obtain approval may result in cost disallowances.

C. FIXED RATES:

If a fixed rate is in this Agreement, it is based on an estimate of the costs for the period covered by the rate. When the actual costs for this period are determined, an adjustment will be made to a rate of a future year(s) to compensate for the difference between the costs used to establish the fixed rate and actual costs.

D. USE BY OTHER FEDERAL AGENCIES:

The rates in this Agreement were approved in accordance with the cost principles promulgated by the Department of Health and Human Services, and should be applied to the grants, contracts and other agreements covered by these regulations subject to any limitations in A above. The hospital may provide copies of the Agreement to other Federal Agencies to give them early notification of the Agreement.

E. OTHER:

If any Federal contract, grant or other agreement is reimbursing indirect costs by a means other than the approved rate(s) in this Agreement, the organization should (1) credit such costs to the affected programs, and (2) apply the approved rate(s) to the appropriate base to identify the proper amount of indirect costs allocable to these programs.

BY THE INSTITUTION:	ON BEHALF OF THE FEDERAL GOVERNMENT:
Dartmouth-Hitchcock Mary Hitchcock Memorial Hospital	DEPARTMENT OF HEALTH AND HUMAN SERVICES
(INSTITUTION)	(AGENCY)
(SIGNATURE)	Darryl W. Mayes -S (SIGNATURE)
Robin Kilfeather-Mackey	Darryl W. Mayes
(NAME)	(NAME)
Chief Financial Officer	Deputy Director, Cost Allocation Services
(TITLE)	(TITLE)
7/15/15	6/23/2015
(DATE)	(DATE) 1324

HHS REPRESENTATIVE: Louie Martillotti

Telephone: (212) 264-2069

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", "Confidential Data", or "Data "(as defined in Exhibit K),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'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 a security policy, which includes successful attempts) 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 documents or mail.

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 required or permitted under this Contract or required by law. 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. 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.

II. METHODS OF SECURE TRANSMISSION OF DATA

1. Application Encryption. If Contractor 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. Contractor may not use computer disks or portable storage devices, such as a thumb drive, as a method of transmitting DHHS Data.
3. Encrypted Email. Contractor 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 Contractor 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. Contractor may not use file hosting services, such as Dropbox or Google Cloud Storage, to transmit Confidential Data.
6. Ground Mail Service. Contractor 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 Contractor is employing portable devices to transmit Confidential Data said devices must be encrypted and password-protected.
8. Open Wireless Networks. Contractor 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 Contractor is employing remote communication to access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.
10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor 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 Contractor 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 DHHS Dataand 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 or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section.. 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 accessed or utilized for purposes of carrying out this contract.
3. The Contractor agrees to provide security awareness and education for its End Users in support of protecting DHHS 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, current, updated, and maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) 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.

Contractor Initials

Date 9/4/19

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor and will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. 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.
2. 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. If the Contractor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the Contractor will ensure End-User will maintain 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.

Contractor Initials

Date 9/6/19

5. 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.

6. 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.

7. 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.

8. Data Security Breach Liability. In the event of any computer security incident, incident, or 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 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.

9. 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, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable health information and as applicable under State law.

10. 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.

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor will notify the State's Privacy Officer, and additional email addresses provided in this section, of any security breach within 24-hours of the time that

the Contractor learns of its occurrence. 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.

12. 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.

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

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, Information Security Office and Program Manager of any Security Incidents and Breaches within 24- hours of the time that the Contractor learns of their occurrence.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. 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
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 contact program and policy:

(Insert Office or Program Name)
(Insert Title)
DHHS-Contracts@dhhs.nh.gov

B. DHHS contact for Data Management or Data Exchange issues:

DHHSInformationSecurityOffice@dhhs.nh.gov

C. DHHS contacts for Privacy issues:

DHHSPrivacyOfficer@dhhs.nh.gov

D. DHHS contact for Information Security issues:

DHHSInformationSecurityOffice@dhhs.nh.gov

E. DHHS contact for Breach notifications:

DHHSInformationSecurityOffice@dhhs.nh.gov

DHHSPrivacy.Officer@dhhs.nh.gov

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION FOR BEHAVIORAL HEALTH
BUREAU OF DRUG AND ALCOHOL SERVICES

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

105 PLEASANT STREET, CONCORD, NH 03301
603-271-6110 1-800-852-3345 Ext. 6738
Fax: 603-271-6105 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

December 27, 2017

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 for Behavioral Health, Bureau of Drug and Alcohol Services, to enter into an agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, for the provision of integrated obstetric, primary care, pediatric, and Medication Assisted Treatment (MAT) for pregnant and postpartum women with opioid use disorder in an amount not to exceed $2,755,443, effective upon date of Governor and Executive Council approval, through June 30, 2019. 100% Federal Funds.

Funds are available in the following account(s) for SFY 2018 and SFY 2019, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office if needed and justified, without approval from Governor and Executive Council.

05-95-92-920510-25590000 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION FOR BEHAVIORAL HEALTH, BUREAU OF DRUG AND ALCOHOL, OPIOID STR GRANT

SFY	Class/Account	Class Title	Job Number	Total Amount
2018	102-500731	Contracts for Program Services	92052559	$ 862,630
2019	102-500731	Contracts for Program Services	92052559	$1,892,813
			Total	$2,755,443

EXPLANATION

The purpose of this request is to provide integrated obstetric care, primary care, pediatric care and Medication Assisted Treatment for pregnant and postpartum women with opioid use disorder and any co-occurring mental health disorders. Medication Assisted Treatment services will be integrated with prenatal and postpartum care, and provided with parenting support and education at eight (8) sites across New Hampshire, including sites in

the high need areas of Belknap and Coos Counties where opioid use disorder treatment services are limited.

The Contractor will deliver these services through both a Perinatal Addiction Treatment Program in Lebanon, NH that is integrated with obstetrics/gynecology and pediatric care on-site and at seven (7) other sites which are obstetrical/gynecological practices that are enhanced with Medication Assisted Treatment services and pediatric care.

The State of New Hampshire was awarded funding authorized through the 21st Century CURES Act by the Substance Abuse and Mental Health Services Administration which is overseeing the process for states to receive federal funding through the State Targeted Response to the Opioid Crisis Grants Program. New Hampshire's application is a joint effort by several state agencies and proposes to use evidence-based methods to expand treatment, recovery and prevention services to targeted populations. These critical funds will strengthen established programs that have had a positive impact on the opioid crisis as well as expanding the capacity for programs that have shown promise in helping individuals battling a substance misuse issue and combatting the epidemic in New Hampshire.

In 2016, the State of New Hampshire experienced four hundred eighty-five (485) deaths from drug overdoses. At present, the State is experiencing an increase in the need for population-specific Substance Use Disorder Treatment and Recovery Support Services for pregnant women due to a rise in Neonatal Abstinence Syndrome in infants born to mothers who have used opioids. Babies with this syndrome experience symptoms of drug withdrawal and require special treatment prior to leaving the hospital. It is critical that providers develop integration of services, approaches to meet individual client needs, and approaches to maximize State and Federal dollars to meet the public's demand for these specific services. The services provided by the Contractor will be comprehensive and focused not only on the mother's recovery, but also on ensuring that the infant is receiving the necessary health and social supports and services to mitigate risk associated with maternal opioid use.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request for Proposals was posted on The Department of Health and Human Services' web site from August 28, 2017 through September 25, 2017. The Department received one (1) proposal. The proposal was reviewed and scored by a team of individuals with program specific knowledge. The review included a thorough discussion of the strengths and weaknesses of the proposals/applications. The Score Summary is attached.

As referenced in the Request for Proposals and in Exhibit C-1, Revisions to General Provisions, of this contract, the Department reserves the option to extend contract services for up to two (2) additional years, contingent upon satisfactory delivery of services, available funding, agreement of the parties and approval of the Governor and Executive Council.

Should the Governor and Executive Council not authorize this request, pregnant and postpartum women in New Hampshire diagnosed with opioid use disorder may not receive the support necessary to overcome their addiction which could negatively impact their health and the health of their newborn child(ren).

Area served: Statewide

Source of Funds: 100% Federal Funds from DHHS, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. CFDA #93.788. FAIN TI080246.

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

Respectfully submitted,

Katja S. Fox
Director

Approved by:

Jeffrey A. Meyers
Commissioner

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Scoring Sheet

Integrated Medication Assisted Treatment for Pregnant and Postpartum Women
RFP Name

RFP-2018-BDAS-05-INTEG
RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital		575	444
2. 0		575	0
3. 0		575	0

Reviewer Names

1. Jamie Powers, Clinical & Recovery Serv Unit Administrator II, BDAS
2. Rhonda Siegel, Administrator II, DPHS Health Mgmt Ofc
3. Abby Shockley, Senior Policy Analyst, Substance Use Servcs.
4. Laurie Heath, Business Adminstr III, DBH/BDAS Finance
5. Don Hunter, Planning and Review Analyst, BDAS

STATE OF NEW HAMPSHIRE
DEPARTMENT OF INFORMATION TECHNOLOGY
27 Hazen Dr., Concord, NH 03301
Fax: 603-271-1516 TDD Access: 1-800-735-2964
www.nh.gov/doit

Denis Goulet
Commissioner

January 3, 2018

Jeffrey A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers:

This letter represents formal notification that the Department of Information Technology (DoIT) has approved your agency's request to enter into a contract with Mary Hitchcock Memorial Hospital, of Lebanon NH as described below and referenced as DoIT No. 2018-047.

This is a request to enter into a contract with Mary Hitchcock Memorial Hospital to provide integrated obstetric, primary care, pediatric, and medication assisted treatment for pregnant and postpartum women with substance use disorder (SUD). This will also include utilizing the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions.

The amount of the contract is not to exceed $2,755,443.00, and shall become effective upon the date of Governor and Executive Council approval through June 30, 2019.

A copy of this letter should accompany the Department of Health and Human Services' submission to the Governor and Executive Council for approval.

Sincerely,

Denis Goulet

DG/kaf
DoIT #2018-047

cc: Bruce Smith, IT Manager, DoIT

FORM NUMBER P-37 (version 5/8/15)

Subject: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women (RFP-2018-BDAS-05-INTEG)

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.

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name NH Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address Dartmouth-Hitchcock One Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number 603-650-8960	1.6 Account Number 05-95-92-920510-25590000	1.7 Completion Date June 30, 2019	1.8 Price Limitation $2,755,443
1.9 Contracting Officer for State Agency E. Maria Reinemann, Esq. Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9330	
1.11 Contractor Signature Edward J Merrens		1.12 Name and Title of Contractor Signatory Edward Merrens, Chief Clinical Officer	

1.13 Acknowledgement: State of New Hampshire, County of Grafton

On 12/15/17, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.

1.13.1 Signature of Notary Public or ~~Justice of the Peace~~
Faith Johnston

1.13.2 Name and Title of Notary or Justice of the Peace

FAITH JOHNSTON
MY COMMISSION EXPIRES SEPT. 21, 2021
NOTARY PUBLIC
NEW HAMPSHIRE

1.14 State Agency Signature Date: 12/28/17	1.15 Name and Title of State Agency Signatory Katja S Fox, Director

1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)*

By: Director, On:

1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)*

By: Megan A. Lenox, Attorney On: 1/3/18

1.18 Approval by the Governor and Executive Council *(if applicable)*

By: On:

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, 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 1.18, 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 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

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

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

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

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials
Date 12.15.17

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.

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

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

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

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

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

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

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials
Date 12.15.17

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 thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation").*

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

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

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

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

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

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

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

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

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

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

Contractor Initials DM

Date 12.15.17

Scope of Services

1. Provisions Applicable to All Services

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

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. The Contractor shall provide comprehensive Medication Assisted Treatment (MAT) for pregnant and postpartum women diagnosed with opioid use disorder (OUD) and co-occurring mental health disorders, integrated with prenatal and postpartum care, and provide parenting support and education for parents at eight (8) sites across the State of New Hampshire, including sites in Belknap and Coos Counties.

2.2. The Contractor shall deliver the required services in Lebanon through the Dartmouth Hitchcock (D-H) Perinatal Addiction Treatment Program (PATP), a comprehensive addiction treatment service with integrated obstetrical/gynecological (OB/Gyn) services and pediatric care offered on-site.

2.3. The Contractor shall ensure delivery of the required services at the seven (7) other sites where services shall be offered by OB/Gyn practices that are enhanced with integrated addiction services and pediatric support.

2.4. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall develop an implementation plan with each site to include, but not be limited to:

2.4.1. Training and implementing new practices, using a combination of Contractor staff and the local site to fill key roles.

2.4.2. Migrating the required core staffing to the practice while the Contractor provides ongoing coaching and consultation for complex situations.

2.4.3. Providing or developing, locally, the adjunct services including, but not limited to child supervision, transportation, and case management as required.

2.5. The Contractor shall provide project management, program consultation, and clinical consultation through their D-H Center for Addiction Recovery in Pregnancy and Parenting team to each site.

2.6. The Contractor shall provide services at all eight (8) sites including, but not limited to:

2.6.1. On-site family support for children.

2.6.2. Peer recovery coaches.

2.6.3. Resource/Employment specialists.

2.6.4. Case management/Care coordination.

2.6.5. Parenting education groups.

2.6.6. Health education.

2.6.7. Social supports including, but not limited to access and/or referrals to food, housing, and transportation services.

2.7. The Contractor shall collaborate with Coos County Family Health Services and implement two (2) of the seven (7) enhanced programs in OB/Gyn practices in Laconia and Littleton by providing intensive support to facilitate the development of an integrated perinatal MAT program at each practice.

2.8. The Contractor shall employ a licensed behavioral health clinician whose responsibilities shall include, but not be limited to:

2.8.1. Conducting weekly visits to each practice for the first six (6) months of the contract.

2.8.2. Providing direct clinical services at all sites.

2.8.3. Supporting and mentoring for weekly MAT visits.

2.8.4. Leading group therapy for participating women.

2.8.5. Collaborating with each site to identify or develop behavioral health resources in the local community.

2.9. The Contractor shall ensure each site identifies at least one (1) provider willing to become waivered to prescribe buprenorphine before the project launch and shall provide initial on-site mentoring to waivered providers at each practice, followed by consultative phone calls over a twelve (12)-month period in a frequency determined necessary by the providers and the Contractor.

2.10. The Contractor shall provide services through the D-H PATP which include, but are not limited to:

2.10.1. Collaborating with the Family Resource Centers, whose services include, but are not limited to:

2.10.1.1. Home visiting.

2.10.1.2. Lactation support.

2.10.1.3. Case management.

2.10.2. Providing parent education groups to program participants on a regular basis which integrate the parenting education curriculum with addiction treatment, so that participants have the opportunity to learn about the impact of substance use on family functioning and healthy child development.

2.10.3. Providing educational sessions to all pregnancy groups which include, but are not limited to "The Period of Purple Crying," safe sleep practices, and car seat safety and are integrated with newborn nursery and outpatient pediatric follow up.

2.10.4. Collaborating with Continuum of Care Coordinators as part of Region 1 Integrated Delivery Network (IDN).

2.10.5. Participating in the Boyle Program, which co-sponsors and facilitates the Child Focus Forum, a bi-monthly collaborative of medical, governmental and community agencies serving parents and children.

2.10.6. Offering co-located child "play time," which provides supportive child engagement that allows women to participate fully in group therapy and receive care without distraction.

2.10.7. Sponsoring co-location of resources such as a food pantry, infant books, and diaper bank through active partnerships with community agencies such as The Upper Valley Haven and The Family Place.

2.11. The Contractor shall ensure patient-centered, effective, integrated care and attention to overdose prevention by employing educational materials which include, but are not limited to:

2.11.1. Center for Disease Control (CDC) opioid prescribing guidelines.

2.11.2. Substance Abuse and Mental Health Services Administration's (SAMHSA's) Opioid Overdose Prevention Toolkit.

2.11.3. State-published Guidance Document on Best Practices: Key Components for Delivering Community Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire.

2.11.4. Care guidelines for OB/GYN providers and delivery hospitals developed by the Northern New England Perinatal Quality Improvement Network (NNEPQIN).

2.12. The Contractor shall provide interim OUD treatment services when the needed treatment services are not available to the participant within forty-eight (48) hours of referral.

2.13. The Contractor shall provide OUD treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model. (More information can be found at http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm.)

2.14. The Contractor shall ensure that participants are able to easily transition between levels of care within a group of services which includes, but is not limited to:

2.14.1. Working with the Continuum of Care Facilitator(s) in the development of a resiliency and recovery oriented system of care (RROSC) in the region(s).

2.14.2. Participating in the Regional Continuum of Care Workgroup(s).

2.14.3. Participating in the Integrated Delivery Network(s) (IDNs).

2.15. The Contractor shall ensure ongoing communication and care coordination with entities involved in the participants' care including child protective services, treatment providers, home visiting services, and pediatric providers.

2.16. The Contractor shall actively participate in the Regional Continuum of Care and IDN Region 1, and maintain good relationships with relevant community partners.

2.17. The Contractor shall assist enhanced sites with creating and hiring for a Recovery Coach position to help participants locate community resources including, but not limited to local recovery centers, peer support meetings, and transitional housing.

2.18. The Contractor shall assist enhanced sites with collaborating with their local/regional Continuum of Care Facilitators and leaders of their regional Integrated Delivery Networks to ensure alignment and coordination across these service networks.

2.19. The Contractor shall collaborate with each enhanced site to modify workflows and electronic records processes to ensure screening and required data collection.

2.20. The Contractor shall modify the obstetrics office electronic health record (EHR) and clinical work flow to ensure required screening activities by OB staff and appropriate required data collection by care coordinators.

2.21. The Contractor shall utilize the State's Prescription Drug Monitoring Program (PDMP) database to mitigate prescription drug diversion or harmful interactions and shall assess each enhanced site's use and support them to develop protocols to monitor the PDMP regularly.

2.22. The Contractor shall develop and implement outreach activities, which may include marketing designed to engage pregnant women with an OUD in the community. The Contractor and Contractor's sites are not required to market themselves publicly as substance use disorder treatment centers.

2.22.1. The Contractor shall ensure that their staff at the Center for Addiction Recovery in Pregnancy and Parenting collaborate with the appropriate D-H department to develop appropriate materials and methods to promote the program throughout our service areas.

2.22.2. The Contractor shall collaborate with each implementing site to ensure marketing materials, if any, and outreach methods used, are consistent with the Contractor's standards and policies in its discretion.

2.22.3. The Contractor shall actively engage with referral networks in the service areas to increase awareness of the program with pregnant women with OUD and to enable the program to be utilized to its greatest capacity.

2.23. The Contractor shall maintain formal and effective partnerships with behavioral health, OUD specialty treatment and Recovery Support Services (RSS), and medical practitioners to meet the needs of the target population and the goals of MAT Expansion.

2.24. The Contractor shall ensure meaningful input of consumers in program assessment, planning, implementation, and improvement which includes, but is not limited to:

2.24.1. Using their Patient Advisory Board which meets quarterly and is composed of participants in long-term recovery.

2.24.2. Engaging participants in all stages of recovery in the development of key program elements through focus groups and targeted interviews.

2.25. The Contractor shall ensure that treatment is provided in a child-friendly environment with childcare support available to participants which includes, but is not limited to:

2.25.1. Developmentally-appropriate childcare support as well as integration with pediatric and developmental services at all enhanced sites.

2.25.2. Co-located child "Play Time" where children engage in developmentally appropriate play while their mothers participate in group treatment and receive care in both Lebanon and Keene.

2.25.3. On-site well-child care at D-H Lebanon PATP.

2.26. The Contractor shall ensure participants' transportation needs are met to maintain participant involvement in the program by utilizing a Resource Specialist whose duties related to transportation may include, but not be limited to:

2.26.1. Assisting participants to enroll in Medicaid transportation services.

2.26.2. Developing a network of support to help with transportation needs.

2.26.3. Helping participants to attain a valid driver's license or an affordable car loan.

2.26.4. Collaborating with Good News Garage or similar programs.

2.26.5. Finding housing in close proximity to social services.

2.27. The Contractor shall use data to support quality improvement including, but not limited to:

2.27.1. Developing, disseminating, and implementing best practices for pregnant and parenting women with OUD, including, but not limited to hosting monthly webinars related to topics such as screening and treatment of co-occurring psychiatric disorders.

2.27.2. Collecting data on participant demographics and more than thirty (30) key perinatal, neonatal, and treatment outcomes for all program participants, using a REDCap database designed for this purpose.

2.27.2.1. REDCap allows de-identified, participant-level data to be entered remotely by sites.

2.27.2.2. Data shall be entered for each participant from the time of entry into the program until three (3) months postpartum. For example, a participant entering care in the late first trimester, data would entered at entry to care, at 24-28 weeks of pregnancy, at delivery, and at three (3) months postpartum.

2.27.2.3. Data shall be utilized for quality improvement purposes and program evaluation, as well as development of targeted services at all sites.

2.27.3. Collecting data on key measures identified by the Department and the Contractor's multidisciplinary stakeholder group and using the data to track performance.

2.27.3.1. The existing REDCap database shall be expanded as needed to include additional measures identified by the Department.

2.27.3.2. Site specific data shall be reviewed quarterly.

2.27.4. Reporting data to sites quarterly and addressing areas flagged for improvement both directly through discussion and process improvement at the individual practice level and through learning collaborative sessions with multiple practices.

2.27.5. Employing a research assistant to support sites with data entry challenges and ensure data quality.

2.27.6. Analyzing the data and promoting quality improvement efforts.

2.28. The Contractor shall maintain the infrastructure necessary to achieve the goals of MAT Expansion for the target population, to meet SAMHSA requirements, and to deliver effective medical care to pregnant and postpartum women with an OUD.

2.29. The Contractor shall participate in the State-funded "Community of Practice for MAT" along with other State-funded projects which include, but are not limited to:

2.29.1. Project-specific trainings.

2.29.2. Quarterly web-based discussions.

2.29.3. On-site Technical Assistance (TA) visits.

2.29.4. Ad hoc communication with expert consultants on MAT clinical care topics such as Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) prevention, diversion risk mitigation, and other relevant issues.

2.30. The Contractor shall participate in the development of a Safe Plan of Care with birth attendants and the New Hampshire Division of Children, Youth, and Families (DCYF) for each infant affected by illegal substance use, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.

2.30.1. The Contractor shall employ a social worker with experience in the Contractor's Child Advocacy and Protection Program.

2.30.2. The Contractor shall ensure that planning and communication regarding the Safe Plan of Care will also involve other community agency supports including, but not limited to home visitation, WIC, housing, and other services central to recovery and parenting.

2.31. The Contractor shall establish formal agreements with hospitals to aid in preparing the hospital system with the clinical policies and procedures necessary to address neonatal abstinence syndrome in the newborn while supporting the mother's recovery.

2.31.1. The Contractor shall engage with the NNEPQIN learning collaborative, the organization that has developed policies and procedures to effectively address neonatal abstinence syndrome while supporting the mother's recovery.

2.32. The Contractor shall have billing capabilities which include, but are not limited to:

2.32.1. Enrolling with Medicaid and other third party payers.

2.32.2. Contracting with managed care organizations and insurance companies for MAT and delivery of prenatal care.

2.32.3. Having a proper understanding of the hierarchy of the billing process.

2.33. The Contractor shall assist the participant with obtaining either on-site or off-site RSS's including, but not limited to:

2.33.1. Transportation.

2.33.2. Childcare.

2.33.3. Peer support groups.

2.33.4. Recovery coach.

2.34. The Contractor shall use the New Hampshire Alcohol and Drug Treatment Locator (http://www.nhtreatment.org) to identify specific services that are available by location, population, and payer to enable patient choice.

2.35. The Contractor shall establish agreements with specialty treatment organizations that can provide higher levels of OUD treatment and co-occurring mental health treatment.

2.36. The Contractor shall deliver parenting and personal development education using evidence-based curriculum including, but not limited to:

2.36.1. Marsha Linehan's Dialectical Behavior Therapy approach to treatment and Lisa Najavits' Seeking Safety curriculum to increase emotion regulation skills in participants to address Post-Traumatic Stress Disorder (PTSD) symptoms and decrease emotional vulnerability that could lead to relapse.

2.36.2. SAMHSA materials, 12-Step information, and other materials that the program has developed to increase participants' knowledge of the disease model of addiction and to enhance understanding of biological vulnerability and the progression of addiction.

2.36.3. Cognitive Behavioral Therapy (CBT), SAMSHA materials, 12-Step materials, and mindfulness-based stress reduction approaches to bolster relapse prevention strategies and improve resiliency.

2.36.4. Duluth Model Domestic Abuse Intervention Programs and Dialectical Behavior Therapy (DBT) to promote healthy relationships and decrease risk of interpersonal violence.

2.36.5. Circle of Security and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curricula to increase parent-child attachment and increase parents' knowledge of healthy child development.

2.37. The Contractor shall improve participants' access to a sober network of support and increased resiliency to relapse which includes, but is not limited to.

2.37.1. Utilizing an on-site Recovery Coach who participates in group therapy sessions and engages one-on-one with participants to provide additional support between sessions.

2.37.2. Inviting representatives from 12-Step groups and peer-run recovery groups on a regular basis to speak to participants.

2.38. The Contractor shall refer relapsing participants to residential or intensive outpatient care and provide support for accessing appropriate services including, but not limited to follow-up care after intensive treatment services are completed.

2.39. The Contractor shall provide parenting supports to participants including, but not limited to:

2.39.1. Parenting groups.

2.39.2. Childbirth education.

2.39.3. Safe sleep education.

2.40. The Contractor shall collaborate with other providers that offer services to pregnant women with an OUD including, but not limited to programs funded by the Cures Act resources for similar populations.

2.41. The Contractor shall ensure compliance with confidentiality requirements, which include, but are not limited to:

2.41.1. Applicable federal and state laws.

2.41.2. HIPAA Privacy Rule.

2.41.3. 42 C.F.R Part 2.

2.41.3.1. The D-H PATP shall be required to follow 42 C.F.R Part 2 rules.

2.41.3.2. The OB/Gyn programs that will be enhanced with integrated addiction services are not required to follow 42 C.F.R. Part 2.

2.42. The Contractor shall participate in all evaluation activities associated with the funding opportunity, including national evaluations.

2.43. The Contractor shall develop and submit a work plan to the Department for review and approval, which describes the process for ensuring the completion of all aspects of the Scope of Services (Section 2), Staffing (Section 3), and Training (Section 4) as outlined in this Contract within thirty (30) days of Governor and Executive Council approval of the Contract. The Contractor shall use four (4) phases when designing the work plan.

2.43.1. Phase 1: The Contractor shall engage in an intensive planning process and simultaneous development of the infrastructure of the Center for Addiction Recovery in Pregnancy and Parenting which will include hiring key staff such as a project manager and gathering more information about the current state at implementation sites.

2.43.2. Phase 2: The Contractor shall solidify services at the D-H Lebanon PATP and D-H Keene so that they fully meet the service requests of this Contract. The Contractor shall also begin the data collection process.

2.43.3. Phase 3: The Contractor shall plan and implement enhanced services at three (3) new sites (Berlin, Manchester, and Nashua).

2.43.4. Phase 4: The Contractor shall use lessons learned from previous implementations to plan and implement enhanced services at the final three (3) sites (Laconia, Littleton, and Dover).

2.44. The Contractor shall maintain policies and procedures and have regular required employee training (at least annually) in the areas of ethical conduct, confidentiality, compliance, cyber security, and conflict of interest.

3. Staffing

3.1. The Contractor shall meet the minimum MAT team staffing requirements to provide the Scope of Services which includes, but is not limited to at least one (1):

3.1.1. Waivered prescriber.

3.1.2. Masters Licensed Alcohol and Drug Counselor (MLADC) or behavioral health provider with addiction training.

3.1.3. Obstetrician or midwife.

3.1.4. Care coordinator.

3.1.5. Non-clinical/administrative staff.

3.2. The Contractor shall ensure that all unlicensed staff providing treatment, education, and/or recovery support services are under the direct supervision of a licensed supervisor.

3.3. The Contractor shall ensure that no licensed supervisor oversees more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.

3.4. The Contractor shall ensure that at least one Certified Recovery Support Worker (CRSW) is available for every fifty (50) participants or portion thereof.

3.5. The Contractor shall ensure that unlicensed staff providing clinical or recovery support services must hold a CRSW within six (6) months of hire or from the effective date of this contract, whichever is later.

4. Training

4.1. The Contractor shall make available initial and on-going training resources to all staff including, but not limited to buprenorphine waiver training for physicians, nurse practitioners, and physician assistants. The Contractor shall develop a plan for Department approval to train and engage appropriate staff.

4.2. The Contractor shall participate in training and technical assistant activities as directed by the Department including, but not limited to the Community of Practice for MAT which may include, but is not limited to:

4.2.1. Project-specific trainings.

4.2.2. Quarterly web-based discussions.

4.2.3. On-site technical assistance visits.

4.2.4. Ad hoc communication with expert consultants regarding MAT clinical care topics including, but not limited to:

4.2.4.1. HCV and HIV prevention.

4.2.4.2. Diversion risk mitigation.

4.2.4.3. Other relevant issues.

4.3. The Contractor shall train staff on relevant topics which may include, but are not limited to:

4.3.1. Integrated care.

4.3.2. Trauma-informed care.

4.3.3. MAT (e.g. prescriber training for buprenorphine).

4.3.4. Care coordination.

4.3.5. Trauma-informed wrap around care/RSS delivery best practices.

4.3.6. Evidence-Based Practices (EBPs) such as Screening, Brief Intervention, and Referral to Treatment (SBIRT).

4.3.7. Buprenorphine waiver trainings, available locally and at websites including, but not limited to:

4.3.7.1. https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

4.3.7.2. https://www.asam.org/education/live-online-cme/buprenorphine-course

4.3.7.3. https://aanp.inreachce.com/Details?groupId=714cb0a9-73b2-4daf-8382-27cbdb70ef5a

4.3.8. Cognitive behavioral therapy, dialectical behavior therapy, motivational enhancement therapy, mindfulness, and relapse prevention.

4.4. The Contractor shall provide ongoing supervision for buprenorphine prescribers with access to consultation from experienced providers.

4.5. The Contractor's Center for Addiction Recovery in Pregnancy and Parenting shall offer online training, CME/CNE events, and monthly learning collaboratives to each practice including, but not limited to:

4.5.1.1. Two (2) hour initial in-service training in preparation for opening clinic regarding providing trauma-informed and recovery-friendly care.

4.5.1.2. Toolkit of training materials.

4.5.1.3. Weekly team meetings on day of clinic facilitated by the behavioral health clinician.

4.5.1.4. Monthly webinar learning collaboratives for all participating practices with rotating topics

4.5.1.5. Quarterly in-person gatherings for all participating practices, focused on relationship building and sharing of experiences, hosted at rotating locations to maximize participation.

4.5.1.6. Annual CME event aimed at all staff involved in this model of care.

4.6. The Contractor shall provide assistance to all sites regarding training and logistics for the distribution of naloxone kits to patients and family members.

4.7. The Contractor shall assist practice staff in attending the following externally provided formal trainings:

4.7.1. CRSW training for prospective Recovery Coaches

4.7.2. Circle of Security training for BHCs and Recovery Coaches

4.7.3. Buprenorphine training for MDs/PAs/ARNPs

4.7.4. Smoking cessation training for any interested staff

4.7.5. Motivational Interviewing training for any interested staff

4.7.6. Additional trainings on trauma-informed care and other evidence based treatment strategies as indicated

5. Reporting

5.1. The Contractor shall gather, monitor, and submit data to the Department monthly. Participant data will be submitted in de-identified, aggregate form to the Department using a Department-approved method. The data being collected includes all data points required in the Treatment Episode Data for Admissions which includes, but is not limited to:

5.1.1. Treatment Setting

5.1.2. Number of prior treatment episodes

5.1.3. Primary source of referral

5.1.4. Age at admission

5.1.5. Pregnancy status

5.1.6. Race/Ethnicity

5.1.7. Education

5.1.8. Employment status

5.1.9. Primary substance

5.1.10. Route of administration

5.1.11. Frequency of use

5.1.12. Age at first use

5.1.13. Co-Occurring Substance Abuse and Mental Health Status

5.1.14. Veteran status

5.1.15. Living arrangements

5.1.16. Primary source of income

5.1.17. Health Insurance status

5.1.18. Primary source of payment

5.1.19. Details for those not-in-labor-force

5.1.20. Marital status

5.1.21. Days waiting to enter treatment

5.1.22. Number of arrests in past 30 days

5.1.23. Frequency at self-help programming 30 days prior to admission

5.2. The Contractor shall report on federally-required data points specific to this funding opportunity quarterly and send the results in de-identified, aggregate form to the Department using a Department-approved method. The required data points include, but are not limited to:

5.2.1. Number of participants with OUD's:

5.2.1.1. In total.

5.2.1.2. Receiving integrated MAT with prenatal care.

5.2.1.3. Receiving care coordination/case management.

5.2.1.4. Receiving peer recovery support services.

5.2.1.5. Participating in parenting education programming.

5.2.1.6. Referred to or placed in recovery housing.

5.2.1.7. Referred to higher levels of care.

5.2.2. Number of providers in the program implementing MAT.

5.2.3. Number of OUD prevention and treatment providers trained by the program including, but not limited to Nurse Practitioners, Physician's Assistants, physicians, nurses, counselors, social workers, and case managers.

5.2.4. Numbers and rates of opioid overdose-related deaths within population served.

5.2.5. Number of children receiving childcare services by MAT program.

5.2.6. Number of infants in the program born with NAS not attributable to the mother taking prescribed MAT medications.

5.2.7. Number of referrals made to DCYF for substance-exposed infants not attributable to the mother taking prescribed MAT medications.

5.3. The Contractor shall require that all MAT-providing implementation sites report on the data points specified by the Department, utilizing a standardized protocol.

5.3.1. Each site will have exclusive access to protected health information for its own participants, and REDCap will be used to facilitate reporting of de-identified, aggregated data.

5.3.2. The Contractor shall provide a research assistant to help sites develop and implement appropriate site-specific data collection strategies to ensure compliance with reporting protocols.

5.4. The Contractor shall provide a final report to the Department within thirty (30) days of the termination of the contract which will include the following de-identified information based on the work plan progress, but shall not be limited to:

5.4.1. Policies and practices established.

5.4.2. Outreach activities.

5.4.3. Demographics of participants.

5.4.4. Outcome data (as directed by the Department).

5.4.5. Participant satisfaction.

5.4.6. Description of challenges encountered and action taken.

5.4.7. Other progress to date.

5.4.8. A sustainability plan to continue to provide MAT services to the target population beyond the completion date of the contract, subject to approval by the Department.

6. Performance Measures

6.1. The following aggregate performance indicators are to be annually achieved and monitored monthly to measure the effectiveness of the agreement:

6.1.1. The Contractor shall ensure that fifty percent (50%) of women referred to the program who consent to treatment and qualify based on clinical evaluation will enter OUD treatment as reported by the Contractor.

6.1.2. The Contractor shall ensure seventy-five percent (75%) of women identified by ASAM criteria as in need of a higher level of care will be referred to treatment services in order to increase referral of pregnant and postpartum women to OUD treatment providers as reported by the Contractor.

6.1.3. The Contractor shall attempt to ensure that NAS rates of infants born to mothers served in this program not attributable to the mother taking MAT medications as prescribed will decline by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.4. The Contractor shall attempt to lower positive urine drug screens for illicit substances for pregnant women served in this program by five percent (5%) from SFY18 to SFY19 as reported by the Contractor.

6.1.5. The Contractor shall seek to help lower reports to DCYF of substance-exposed infants born to mothers served in this program, not attributable to the mother taking MAT medications as prescribed by five percent (5%) from SFY18 to SFY19. This performance measure will be reported by the Contractor and through the use of collected hospital and DCYF data.

6.2. Annually, the Contractor shall develop and submit to the Department, a corrective action plan for any performance measure that was not achieved.

Methods and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Form P-37, Block 1.8, Price Limitation for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. The Contractor agrees to provide the services in Exhibit A, Scope of Service in compliance with funding requirements. Failure to meet the scope of services may jeopardize the funded contractor's current and/or future funding.
3. This contract is funded with funds from the US Department of Health and Human Services, Substance Abuse and Mental Health Administration, Catalog of Federal Domestic Assistance (CFDA #) 93.788, Federal Award Identification Number (FAIN) TI080246.
4. Payment for said services shall be made monthly as follows:
   - 4.1. Payment shall be on a cost reimbursement basis for actual expenditures incurred in the fulfillment of this agreement, and shall be in accordance with the approved line item.
   - 4.2. The Contractor will submit an invoice in a form satisfactory to the State by the twentieth (20th) working day of each month, which identifies and requests reimbursement for authorized expenses incurred in the prior month. The invoice must be completed, signed, dated, and returned to the Department in order to initiate payment. The Contractor agrees to keep records of their activities related to Department programs and services.
   - 4.3. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice, subsequent to approval of the submitted invoice and if sufficient funds are available. Contractors will keep detailed records of their activities related to DHHS-funded programs and services.
   - 4.4. The final invoice shall be due to the State no later than forty (40) days after the contract Form P-37, Block 1.7 Completion Date.
   - 4.5. In lieu of hard copies, all invoices may be assigned an electronic signature and emailed to:

     Department of Health and Human Services
     Division of Behavioral Health
     129 Pleasant Street
     Concord, NH 03301
     Email addresses: laurie.heath@dhhs.nh.gov AND abby.shockley@dhhs.nh.gov
   - 4.6. Payments may be withheld pending receipt of required reports or documentation as identified in Exhibit A, Scope of Services, and in this Exhibit B.
5. Notwithstanding paragraph 18 of the General Provisions P-37, changes limited to adjusting amounts between budget line items, related items, amendments of related budget exhibits within the price limitation, and to adjusting encumbrances between State Fiscal Years, may be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1
Budget for SFY 2018

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: January 1, 2018 - June 30, 2018

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 339,929	$ 98,710	$ 438,639	$ -	$ -	$ -	$ 339,929	$ 98,710	$ 438,639
2. Employee Benefits	$ 87,361	$ 25,267	$ 112,628	$ -	$ -	$ -	$ 87,361	$ 25,267	$ 112,628
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 60,000	$ 17,580	$ 77,580	$ -	$ -	$ -	$ 60,000	$ 17,580	$ 77,580
Office	$ 16,509	$ 4,835	$ 21,335	$ -	$ -	$ -	$ 16,509	$ 4,835	$ 21,335
6. Travel	$ 10,000	$ 2,930	$ 12,930	$ -	$ -	$ -	$ 10,000	$ 2,930	$ 12,930
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
Telephone		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 30,000	$ 14,600	$ 44,600	$ -	$ -	$ -	$ 30,000	$ 14,600	$ 44,600
11. Staff Education and Training	$ 40,000	$ 11,770	$ 51,770	$ -	$ -	$ -	$ 40,000	$ 11,770	$ 51,770
12. Subcontracts/Agreements	$ 73,315	$ 7,325	$ 80,640	$ -	$ -	$ -	$ 73,315	$ 7,325	$ 80,640
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 678,183	$ 184,839	$ 863,836	$ -	$ -	$ -	$ 678,183	$ 184,839	$ 863,836
Indirect As A Percent of Direct		27.2%							

Contractor Initials
Date 9.15.17
12.

Exhibit B-2
Budget for SFY 2019

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital

Budget Request for: Integrated Medication Assisted Treatment for Pregnant and Postpartum Women

Budget Period: July 1, 2018 -June 30, 2019

Line Item	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 868,506	$ 253,896	$ 1,120,392	$ -	$ -	$ -	$ 868,506	$ 253,896	$ 1,120,392
2. Employee Benefits	$ 229,427	$ 67,222	$ 296,649	$ -	$ -	$ -	$ 229,427	$ 67,222	$ 296,649
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Lab		$ -	$ -	$ -	$ -	$ -		$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ 5,000	$ 1,485	$ 6,485	$ -	$ -	$ -	$ 5,000	$ 1,485	$ 6,485
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 40,000	$ 11,720	$ 51,720	$ -	$ -	$ -	$ 40,000	$ 11,720	$ 51,720
7. Occupancy		$ -	$ -	$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ 4,000	$ 1,172	$ 5,172	$ -	$ -	$ -	$ 4,000	$ 1,172	$ 5,172
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ 1,500	$ 440	$ 1,940	$ -	$ -	$ -	$ 1,500	$ 440	$ 1,940
11. Staff Education and Training	$ 7,500	$ 2,198	$ 9,698	$ -	$ -	$ -	$ 7,500	$ 2,198	$ 9,698
12. Subcontracts/Agreements	$ 378,803	$ 21,975	$ 400,778	$ -	$ -	$ -	$ 378,803	$ 21,975	$ 400,778
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 1,533,736	$ 360,077	$ 1,893,813	$ -	$ -	$ -	$1,533,736	$360,077	$1,893,813
Indirect As A Percent of Direct		23.5%							

Contractor Initials
Date 5/17/18

SPECIAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed

19.5. DHHS shall, at its discretion, review and approve all subcontracts.

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

DEFINITIONS

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

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

DEPARTMENT: NH Department of Health and Human Services.

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

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

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

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

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

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

REVISIONS TO GENERAL PROVISIONS

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

   4. CONDITIONAL NATURE OF AGREEMENT.

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

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

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

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

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

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

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

3. Extension:

   The Department reserves the right to renew the Contract for up to two (2) additional years, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

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

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

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

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

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

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

Contractor Name:

12.15.17
Date

Edward Merrens
Name:
Title: Chief Clinical Officer

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Contractor Name:

12.15.17
Date

Edward J. Menezes
Name:
Title:

EM
Contractor Initials

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:

12.15.17
Date

Name:
Title:

Contractor Initials EM
Date 12.15.17

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Contractor Name:

12·15·17
Date

Name:
Title:

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:

12.15.17
Date

Edmund J Mercer
Name:
Title:

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

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

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

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

Contractor Name:

12.15.17
Date

Name:
Title:

FORM A

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

1. The DUNS number for your entity is: 06-99102-97

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: _____

DHHS INFORMATION SECURITY REQUIREMENTS

1. Confidential Information: In addition to Paragraph #9 of the General Provisions (P-37) for the purpose of this RFP, the Department's Confidential information 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 Personal Health Information (PHI), Personally Identifiable Information (PII), Federal Tax Information (FTI), Social Security Numbers (SSN), Payment Card Industry (PCI), and or other sensitive and confidential information.

2. The vendor will maintain proper security controls to protect Department confidential information collected, processed, managed, and/or stored in the delivery of contracted services. Minimum expectations include:

   2.1. 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.).

   2.2. Maintain appropriate authentication and access controls to contractor systems that collect, transmit, or store Department confidential information where applicable.

   2.3. Encrypt, at a minimum, any Department confidential data stored on portable media, e.g., laptops, USB drives, as well as when transmitted over public networks like the Internet using current industry standards and best practices for strong encryption.

   2.4. 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.

   2.5. Provide security awareness and education for its employees, contractors and sub-contractors in support of protecting Department confidential information

   2.6. Maintain a documented breach notification and incident response process. The vendor will contact the Department within twenty-four 24 hours to the Department's contract manager, and additional email addresses provided in this section, of 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.

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

      Breach notifications will be sent to the following email addresses:

      2.6.1.1. DHHSChiefInformationOfficer@dhhs.nh.gov

      2.6.1.2. DHHSInformationSecurityOffice@dhhs.nh.gov

   2.7. If the vendor will maintain any Confidential Information on its systems (or its sub-contractor systems), the vendor 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 vendor 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, or otherwise physically destroying the media (for example, degaussing). The vendor 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 vendor prior to destruction.

2.8. If the vendor will be sub-contracting any core functions of the engagement supporting the services for State of New Hampshire, the vendor 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 vendor, including breach notification requirements.

3. The vendor 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 vendor and any applicable sub-contractors prior to system access being authorized.

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

5. The vendor will work with the Department at its request to complete a survey. The purpose of the survey is to enable the Department and vendor to monitor for any changes in risks, threats, and vulnerabilities that may occur over the life of the vendor engagement. The survey will be completed annually, or an alternate time frame at the Departments discretion with agreement by the vendor, or the Department may request the survey be completed when the scope of the engagement between the Department and the vendor changes. The vendor 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 appropriate authorized data owner or leadership member within the Department.