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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION FOR BEHAVIORAL HEALTH

BUREAU OF MENTAL HEALTH SERVICES

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

105 PLEASANT STREET, CONCORD, NH 03301
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October 8, 2018

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 (DHHS), Division for Behavioral Health, Bureau of Mental Health Services to **retroactively** exercise a renewal option to an existing agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, to complete a training program for First Episode Psychosis, by extending the completion date from September 30, 2018 to June 30, 2019, with no change to the price limitation of $197,164.41, effective retroactively to October 1, 2018 upon date of Governor and Executive Council approval. This is a no cost extension. 100% Federal Funds

This agreement was originally approved by the Governor and Executive Council on September 27, 2019, Item #24.

Funds are available in the following accounts for SFY 2019, with authority to adjust amounts within the price limitation and adjust encumbrances between State Fiscal Years through the Budget Office without further approval from Governor and Executive Council if needed and justified.

05-95-092-922010-4120-102 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF BEHAVIORAL HEALTH, BUREAU OF MENTAL HEALTH SERVICES, MENTAL HEALTH BLOCK GRANT

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2018	102/500731	Contracts for Prog Svc	92224120	$161,820.86
SFY 2019	102/500731	Contracts for Prog Svc	92224120	$35,343.55
			Total	**$197,164.41**

EXPLANATION

This request is **retroactive** because there was a delay in the startup for the training and the Department needs to ensure the Greater Nashua Community Mental Health Center (CMHC) has a full year of access to training on First Episode Psychosis (FEP) treatment services. Without a full twelve (12) months of training and supervision, the clinicians will not be certified to provide evidence-based First Episode Psychosis interventions.

This request is a no cost extension because the full twelve (12) months of training and supervision on the FEP treatment services have not been completed due to a delay in the contract startup date. Therefore, no additional funding to the existing contract is required.

FEP treatment services are used to treat individuals' ages fifteen (15) to thirty-five (35) years who present symptoms of a psychotic disorder and meet State eligibility criteria for either a Serious Emotional Disturbance (SED) or a Serious Mental Illness (SMI).

First Episode Psychosis is a comprehensive approach to treatment for individuals with first or early stage manifestation of a psychotic disorder. Early intervention services for First Episode Psychosis can improve symptoms and restore functioning in a manner superior to standard care services. First Episode Psychosis treatment services include Coordinated Specialty Care (CSC), delivered by a team of several professionals with different levels and areas of expertise.

Each year, approximately 100,000 young people in the United States experience a first episode of mental illness. Long delays between the onset of mental illness and effective treatment are typical. A 2015 study found that of more than four-hundred (400) people in the United States with early symptoms, half experienced symptoms for nearly 18 months before beginning treatment. This is almost six (6) times the World Health Organization's quality standard of a maximum 12 weeks. Research shows that integrated coordinated specialty care effectively reduces symptoms and improves functioning.

Findings reported by the National Institute for Mental Health show that over a period of two (2) years, clients at CSC clinics stayed in treatment longer, experienced greater improvement in their symptoms, interpersonal relationships, and in their quality of life, and were more involved in work or school compared to clients at typical-care sites.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request for Proposals for a trainer for FEP Services was posted on the DHHS website from November 30, 2016 through January 30, 2017.

As referenced in the Request for Proposals and in Exhibit C-1 of this contract, this Agreement has the option to extend 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.

The Department is requesting to extend this contract for nine (9) months to allow the vendor to complete First Episode Psychosis training services to the Nashua Community Mental Health Center. Completion of the training will ensure the CMHC is certified in providing FEP treatment services.

Should the Governor and Executive Council not authorize this request the Department would not have the resources to train the Greater Nashua Community Mental Health Center to appropriately treat First Episode Psychosis, which may increase the need for emergency room visits, which would negatively impact the citizens of New Hampshire.

Area served: Statewide

Source of Funds: 100% Federal Funds. Catalog of Federal Domestic Assistance (CFDA) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-18.

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

State of New Hampshire
Department of Health and Human Services
Amendment #1 to the Trainer for First Episode Psychosis

This 1st Amendment to the Trainer for First Episode Psychosis contract (hereinafter referred to as "Amendment #1") dated this 10th day of September, 2018, 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 non-profit corporation with a place of business at One Medical Center Drive, Lebanon, New Hampshire 03756.

WHEREAS, pursuant to an agreement (the "Contract") approved by the Governor and Executive Council on September 27, 2017, (Item #24), the Contractor agreed to perform certain services based upon the terms and conditions specified in the Contract 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 and terms and conditions of the contract; and

WHEREAS, pursuant to Form P-37, General Provisions, Paragraph 18, the State may modify the scope of work and the payment schedule of the contract 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, with no change to price limitation, 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:

   June 30, 2019.

2. Form P-37, General Provisions, Block 1.9, Contracting Officer for State Agency, to read:

   Nathan White, Director.

3. Form P-37, General Provisions, Block 1.10, State Agency Telephone Number, to read:

   603-271-9631.

4. Delete Exhibit A in its entirety and replace with Exhibit A Amendment #1.
5. Delete Exhibit B Method and Conditions Precedent to Payment, in its entirety and replace with Exhibit B Amendment #1, Method and Conditions Precedent to Payment.
6. Delete Exhibit B-1 Budget, in its entirety and replace with Exhibit B-1 Budget Amendment #1.
7. Delete Exhibit B-2 Budget, in its entirety and replace with Exhibit B-2 Budget Amendment #1.
8. Add Exhibit B-3 Budget Amendment #1.

This amendment shall be effective 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

10/3/18
Date

[signature]
Name: Katja S Fox
Title: Director

Mary Hitchcock Memorial Hospital

9/28/18
Date

[signature]
Name: Edward J. Merrens
Title: Chief Clinical Officer

Acknowledgement of Contractor's signature:

State of New Hampshire County of Grafton on September 28 2018, 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]
Signature of Notary Public or Justice of the Peace

Laura Rondeau - Notary Public
Name and Title of Notary or Justice of the Peace

My Commission Expires: April 19, 2022

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

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

OFFICE OF THE ATTORNEY GENERAL

10/10/18
Date

Name: Megan A. Yaple
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 will 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 coordinate and establish a Coordinated Specialty Care (CSC) team for the Nashua Community Mental Health Center (CMHC).

2.2. The Contractor shall provide training to the Nashua CMHC on First Episode Psychosis Treatment Services used to treat individuals ages fifteen (15) to thirty-five (35) who present with symptoms of a psychotic disorder and meet State eligibility criteria for either a:

2.2.1. Serious Emotional Disturbance (SED) or Serious Emotional Disturbance with Interagency Involvement (SED-IA) as determined through the use of the Child and Adolescent Needs and Strengths (CANS) assessment; or

2.2.2. Serious Mental Illness (SMI) as determined through the use of the Adult Needs and Strengths Assessment (ANSA).

2.3. The Contractor shall provide a training program to ensure the Nashua Community Health Center can implement First Episode Psychosis (FEP) treatment services and continue those services beyond the training period, which shall include, but not be limited to:

2.3.1. Initial Assessments.

2.3.2. Clinical and Support Skills.

2.3.3. Coordination of FEP treatment.

2.4. The Contractor shall ensure that all materials for trainings shall clearly indicate that no Protected Health Information (PHI), Personally Identifiable Information (PII), or other confidential information shall be revealed by trainees during training sessions or during any consultations with Contractor or Sub-Contractors.

2.5. The Contractor shall train Nashua CMHC staff in the FEP NAVIGATE Model, which includes but is not limited to:

2.5.1. Training FEP team members in fundamental information about FEP.

2.5.2. Training on how to use joint decision-making with clients and natural supports.

2.5.3. Specialty training for specific staff roles, which includes but is not limited to:

2.5.3.1. Motivational interviewing strategies.

2.5.3.2. Cognitive-behavioral strategies.

2.5.3.3. Strategies for involving family members and other supporters.

2.5.4. Clinical and support skills that will enable all team members to:

2.5.4.1. Use shared decision-mailing with clients, family members and other supporters.

2.5.4.2. Identify characteristics of individuals with first episode or early psychosis.

2.5.4.3. Describe how clients with first episode schizophrenia differ from those who experience multi-episode schizophrenia.

2.5.4.4. Identify the key needs of individuals with first or early psychosis.

2.5.4.5. Contribute to the weekly FEP NAVIGATE team meetings.

2.5.4.6. Identify key outcomes that can be improved by clients who participate in FEP treatment.

2.6. The Contractor shall ensure the Nashua CMHC FEP team includes, but are not limited to:

2.6.1. A Program Director who is trained to:

2.6.1.1. Educate the community on FEP in order to increase early recognition of psychosis.

2.6.1.2. Recruit individuals who have begun to experience psychosis.

2.6.1.3. Lead the FEP team.

2.6.2. A Family Education (FE) Clinician (who may also be the Program Director) who is trained to:

2.6.2.1. Assist natural supports in learning:

2.6.2.1.1. General information about psychosis

2.6.2.1.2. How to manage psychosis.

2.6.2.1.3. How to support each other and build 'family resiliency.'

2.6.2.2. Conduct outreach and recruitment to community agencies.

2.6.2.3. Evaluate potential clients for the NAVIGATE program.

2.6.2.4. Use engagement strategies to involve clients in treatment.

2.6.2.5. Conduct weekly team meetings and collaborative treatment planning meetings.

2.6.2.6. Identify common reactions in family members of individuals with FEP.

2.6.2.7. Use engagement strategies to involve natural supports in treatment.

2.6.2.8. Conduct illness education sessions with natural supports of persons with early psychosis.

2.6.2.9. Identify and teach coping strategies for natural supports in order to assist them in responding to clients in a supportive manner.

2.6.2.10. Teach communication and problem solving skills to the client's natural supports.

2.6.2.11. Assist natural supports to identify and strengthen their own resiliency.

2.6.3. A Prescriber (psychiatrist, nurse practitioner or physician's assistant) who is trained to:

2.6.3.1. Use low doses of medications to treat FEP.

2.6.3.2. Understand special issues of relevance to individuals experiencing FEP, which may include but is not limited to:

2.6.3.2.1. Avoiding authoritarian approaches.

2.6.3.2.2. Using strategies for accommodating client ambivalence

2.6.3.3. Identify early signs that an individual sis developing symptom of psychosis.

2.6.3.4. Describe the differences between recommended medication sequences for first episode and multi-episode schizophrenia.

2.6.3.5. Integrate the use of the Client Self-Questionnaire in client appointments.

2.6.3.6. Use strategies for joint decision-making as it applies to prescribing medication for clients.

2.6.3.7. Use strategies for retaining early phase psychosis clients in treatment.

2.6.3.8. Describe outcome differences between RAISE-ETP (FEP NAVIGATE) treatment programs and standard care for early phase psychosis.

2.6.4. An Individual Resiliency Trainer (IRT) who is trained to:

2.6.4.1. Assist individuals identify and work towards their goals

2.6.4.2. Teach individuals strategies and skills to build resiliency in coping with psychosis while staying on track with their lives.

2.6.4.3. Focus on individual strengths and resiliency to assist with personal recovery goal setting.

2.6.4.4. Identify strategies that individuals can use to cope with psychosis.

2.6.4.5. Educate clients about the negative effects of substance use on psychosis and provide a message of hope and optimism for overcoming substance use problems.

2.6.4.6. Assist clients with processing the experience of having a first episode of psychosis.

2.6.4.7. Use cognitive behavioral therapy techniques such as cognitive restructuring.

2.6.4.8. Use psychoeducational techniques to teach clients about psychosis and recover.

2.6.5. A Supported Employment And Education (SEE) Specialist) trained to:

2.6.5.1. Assist individuals identify their educational and/or employment goals.

2.6.5.2. Assist individuals with achieving their educational and/or employment goals.

2.6.5.3. Identify key principles for supporting individuals in pursuing evaluation and employment goals.

2.6.5.4. Collaborative complete a Career Inventory.

2.6.5.5. Use strategies to assist individuals with identifying specific career goals.

2.6.5.6. Provide rapid job search and rapid school search to clients, based on client preference.

2.6.5.7. Develop job and school opportunities in the community for FEP clients.

2.6.5.8. Provide follow along supports for clients who have obtained a job or enrolled in school.

2.6.6. A specified FEP team member or a separate case manager trained to:

2.6.6.1. Trained to assist individuals obtain needed services through community resources, such as housing and transportation.

2.6.7. A Peer Support who is either a specified FEP team member or and individual from an outside peer specialist program who is trained to:

2.6.7.1. Assist clients by sharing experiences of recovery.

2.6.7.2. Assist clients to get back on track with their lives, which may include, but is not limited to:

2.6.7.2.1. Working.

2.6.7.2.2. Attending school.

2.6.7.2.3. Fostering positive relationships.

2.6.7.2.4. Developing a strong support system.

2.7. The Contractor shall implement FEP NAVIGATE Training in four phases, as approved by the Department, which include:

2.7.1. Phase 2 – Staff Training – The Contractor shall provide intensive 'hands-on' in-person training in the NAVIGATE components for the team(s). Intensive staff training shall include, but is not limited to:

2.7.1.1. Providing Consultation calls for the Nashua CMHC team in the following manner:

2.7.1.1.1. Twelve (12) calls for the Prescriber.

2.7.1.1.2. Eighteen (18) calls each for the Director/Family Clinician, IRT and SEE.

2.7.1.2. Providing one (1) day of in-person SEE training and site visit in the Nashua community.

2.7.2. Phase 3 – Consultation and Fidelity Monitoring for Successful Implementation – The Contractor shall ensure NAVIGATE Trainer/Consultants conduct follow-up telephone consultation to the Nashua CMHC on actively using NAVIGATE components, including trouble-shooting the overall implementation of the model (beginning the first month following the in-person training and continuing for up to one (1) year following the in-person training). The Contractor shall:

2.7.2.1. Provide monthly consulting calls to the prescriber for up to twelve (12) months after completing the initial training.

2.7.2.2. Ensure prescriber fidelity by documenting prescriber practices and reviewing practices post implementation.

2.7.2.3. Ensure clinical fidelity by reviewing case presentations and reviewing random cases post implementation.

2.7.2.4. Conduct consultation calls once every two weeks to the Director/Family Clinician, IRT Clinician and SEE Specialist.

2.7.2.5. Tape and rate Family Clinician and IRT Fidelity Sessions to establish clinical fidelity, based on the fidelity scales established during the RAISE research phase of NAVIGATE.

2.7.2.6. Observe; by tape, joining by telephone or by on-site visit; and rate a minimum of four (4) team meetings to ensure Director Fidelity

2.7.2.7. Review regular summaries of weekly team meetings conducted by the Director to ensure Director Fidelity and submit summaries on a monthly basis.

2.7.2.8. Conduct SEE Fidelity review activities which shall include, but not be limited to:

2.7.2.8.1. Documentation of completed career inventories and community job development.

2.7.2.8.2. Record keeping on contacts with clients and community resources.

2.7.2.8.3. Case presentations.

2.7.2.9. In consultation with the Department, and with Department approval, conduct a minimum of one (1) full day on-site observation of the SEE in the clinic and in the community.

2.7.3. Phase 4 – In consultation with the Department, and with Department approval, the Contractor shall evaluate procedures for the following seeking Clinical Certification:

2.7.3.1. One (1) Prescriber;

2.7.3.2. One (1) Director;

2.7.3.3. One (1) Family Clinician;

2.7.3.4. Two (2) IRTs; and

2.7.3.5. One (1) SEE.

2.8. In consultation with the Department, and with Department approval, the Contractor shall evaluate certification requirements to FEP team members, which shall include, but not be limited to:

2.8.1. Requirements for prescriber certification, that include but are not limited to:

2.8.1.1. Participation in a minimum of ten (10) prescriber consultation calls.

2.8.1.2. Meeting fidelity criteria that include, but are not limited to:

2.8.1.2.1. Providing consultation data that indicates a minimum of eighty per cent (80%) of clients served are being prescribed according to the NAVIGATE model.

2.8.1.2.2. Providing consultation data regarding laboratory result and how those results have been addressed.

2.8.2. Requirements for director certification, that include but are not limited to:

2.8.2.1. Participation in a minimum of fourteen (14) consultation calls, of which are scheduled twice per month for the first six (6) months and once per month for the second six (6) months.

2.8.2.2. Providing monthly written summary reports, in accordance with the Director Manual, to the Family Clinician consultant, which shall include but not be limited to the number of following meetings that were held:

2.8.2.2.1. NAVIGATE team meetings.

2.8.2.2.2. IRT supervision.

2.8.2.2.3. Family supervision.

2.8.2.2.4. SEE supervison.

2.8.2.2.5. Collaborative treatment planning meetings.

2.8.2.2.6. Accompaniments of SEE specialist community visits.

2.8.2.3. Arranging a minimum of four (4) team meetings (one per quarter) that include the NAVIGANT consultant by speaker phone.

2.8.2.4. Responding to the NAVIGATE consultant's feedback on team meetings.

2.8.2.5. Meeting fidelity criteria that includes, but is not limited to:

2.8.2.5.1. Conducting a minimum of eighty per cent (80%) of the required meetings.

2.8.2.5.2. Achieving an average of three (3) on the Director Fidelity Scale for a minimum of three (3) team meetings that were observed.

2.8.2.5.3. Achieving an average of three (3) on the Team Fidelity Scale as assessed by the NAVIGATE Director/Family consultant.

2.8.3. Requirements for IRT Clinician certification, that include but are not limited to:

2.8.3.1. Participation in a minimum of forty-two (42) weekly clinical meetings about IRT.

2.8.3.2. Audiotaping IRT sessions and completing IRT contact sheets.

2.8.3.3. Submitting taped IRT sessions and completed IRT contact sheets to the NAVIGATE IRT Consultant.

2.8.3.4. Responding to NAVIGATE consultant feedback on tapes and contact sheets providing in sub section 2.7.3.3.

2.8.3.5. Submitting tapes from a minimum of two (2) clients at different stages of IRT.

2.8.3.6. Meeting IRT fidelity criteria for both standard and individualized modules, which includes but are not limited to:

2.8.3.6.1. Receiving a minimum rating of three (3) on the IRT fidelity score for quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.

2.8.3.6.2. Receiving a minimum rating of three (3) on the RIRT fidelity score for the overall quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.

2.8.4. Requirements for Family Clinician certification, that include but are not limited to:

2.8.4.1. Participation in a minimum of fourteen (14) consultation calls with the NAVIGATE Consultant.

2.8.4.2. Audiotaping family sessions and completing family contact sheets in accordance with the Family Consultant Manual.

2.8.4.3. Submitting taped family sessions and completed family contact sheets to the NAVIGATE Consultant.

2.8.4.4. Responding to the NAVIGATE Consultant's feedback regarding the sessions in Section 2.7.4.2.

2.8.4.5. Working with a minimum of two (2) families throughout the educational sessions to completion.

2.8.4.6. Meeting family clinician fidelity criteria, which include but are not limited to:

2.8.4.6.1. Receiving a rating of three (3) on 'Overall quality of session' for three (3) of the four (4) rated sessions on a minimum of two (2) families, for a total of eight (8) rated sessions.

2.8.4.6.2. Audiotaping and submitting a minimum of one consultation session for a minimum of two (2) families to the NAVIGATE consultant for rating and feedback.

2.8.5. Requirements for SEE Specialist certification, that include but are not limited to:

2.8.5.1. Participating in a minimum of forty-two (42) meetings about SEE.

2.8.5.2. Participating in a one-day site visit with SEE NAVIGATE Consultant while conducting business in the community.

2.8.5.3. Providing sufficient information to the SEE NAVIGATE Consultant in order for the consultant to complete the NAVIGATE SEE Fidelity Scale, which may include role plays with the consultant in order to complete the entire assessment.

2.8.5.4. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to employment.

2.8.5.5. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to education.

2.8.5.6. Meeting SEE Specialist Fidelity criteria, which include but are not limited to:

2.8.5.6.1. Demonstration of satisfactory performance on job development skills, educational opportunity development skills and observed interactions with clients, natural supports, employers and educators.

2.8.5.6.2. Demonstration of satisfactory ratings on the NAVIGATE SEE Fidelity Scale.

2.8.5.6.3. Presentation of a minimum of two (2) cases to the consultant showing evidence of fulfilling a minimum of 80% of SEE principles.

2.9. The Contractor shall provide Team Fidelity and Clinical Provider certification requirements to the Nashua CMHC, which shall include, but not be limited to:

2.9.1. Information that indicates FEP teams must provide fully integrated NAVIGATE services to a minimum of five (5) clients for a period of not less than nine (9) months.

2.9.2. Observation provided by NAVIGATE through consultation calls with the director, team meetings and reviews of records.

3. Reporting

3.1. The Contractor shall provide quarterly reports that include, but are not limited to:

3.1.1. A narrative summary of activities completed for the previous quarter that includes, but is not limited to:

3.1.1.1. Specific contacts made to Nashua CMHC.

3.1.1.2. Plan for the following quarter to overcome barriers experienced in the previous quarter.

3.1.2. Assessment of agencies and support provided to agencies for the purpose of readiness to implement the NAVIGATE program.

3.1.3. All reports provided pursuant to this contract will contain de-identified aggregate data only. No PHI, PII, or confidential information will be included. The Contractor shall not receive any PHI, PII or confidential information from any CMHC staff as a result of this contract.

4. Deliverables

4.1. The Contractor shall provide consultation calls within thirty (30) days of the completed training.

4.2. The Contractor shall begin the clinical certification process, which includes but may not be limited to:

4.2.1. Taping IRT and family sessions.

4.2.2. Reviewing SEE logs.

4.2.3. Reviewing psychiatrists prescribing practices.

4.3. In consultation with the Department, and with Department approval, the Contractor shall provide one (1) full day of SEE training and site visit in the Nashua community for Fidelity purposes as part of the clinical certification process by June 30, 2019.

4.4. In consultation with the Department, and with Department approval, the Contractor shall evaluate the eligibility of clinical certification for team members by June 30, 2019.

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. This contract is funded with federal funds. Department access to supporting funding for this project is dependent upon the criteria set forth in the Catalog of Federal Domestic Assistance (CFDA) (https://www.cfda.gov) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-17.
3. The Contractor shall use and apply all contract funds for authorized direct and indirect costs to provide services in Exhibit A, Scope of Services, in accordance with Exhibit B-1, Budget through Exhibit B-3 Budget Amendment #1.
4. The Contractor shall not use or apply contract funds for capital additions or improvements, entertainment costs, or any other costs not approved by the Department.
5. Payment for services provided in accordance with Exhibit A, Scope of Services, shall be made as follows:
   - 5.1. Payments shall be made on cost reimbursement basis only, for allowable expenses and in accordance with Exhibits B-1, Budget through Exhibit B-3 Budget Amendment #1.
   - 5.2. Allowable costs and expenses shall include those expenses detailed in Exhibit B-1, Budget through Exhibit B-3 Budget Amendment #1.
   - 5.3. The Contractor shall submit monthly invoices using invoice forms provided by the Department, and will reference contract budget detail on each invoice.
   - 5.4. The Contractor shall submit supporting documentation and required reports in Exhibit A, Scope of Services, Section 4, that support evidence of actual expenditures, in accordance with Exhibit B-1, Budget through Exhibit B-3 Budget Amendment #1, for the previous month by the tenth (10th) working of the current month.

Exhibit B Amendment #1

5.5. The invoices for services outlined in Exhibit B-1, Budget, through Exhibit B-3 Budget Amendment #1 shall be submitted preferably by e-mail on Department approved invoices to:

State Planner or Designee
Department of Health and Human Services
Bureau of Mental Health Services
105 Pleasant Street
Concord, NH 03301
beth.nichols@dhhs.nh.gov

5.6. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement.

6. A final payment request shall be submitted no later than forty (40) days from the Form P37, General Provisions, Contract Completion Date, Block 1.7.
7. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Contract may be withheld, in whole or in part, in the event of noncompliance with any State or Federal law, rule or regulation applicable to the services provided, or if the said services have not been completed in accordance with the terms and conditions of this Agreement.
8. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to transfer the funds within the budgets in Exhibit B-1 Budget and Exhibit B-3 Budget Amendment #1, and within the price limitation, can 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
Amendment #1

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis
(Name of RFP)

Budget Period: State Fiscal Year (SFY) 2018, July 1, 2017 - June 30, 2018

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 1,625.00	$ 476.13	$ 2,101.13	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ 568.75	$ 166.64	$ 735.39	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ 111,320.00	$ 32,616.76	$ 143,936.76	$ -	$ -	$ -	$ 46,686.70	$ 13,679.20	$ 60,365.90
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ 1,350.00	$ 395.55	$ 1,745.55	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 6,287.73	$ 1,842.30	$ 8,130.03	$ -	$ -	$ -	$ 4,404.43	$ 1,290.50	$ 5,694.93
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ 4,000.00	$ 1,172.00	$ 5,172.00	$ -	$ -	$ -	$ 549.79	$ 161.09	$ 710.88
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 125,151.48	$ 36,669.38	$ 161,820.86	$ -	$ -	$ -	$ 51,640.92	$ 15,130.79	$ 66,771.71

Indirect As A Percent of Direct 29.30%

Contractors Initials EMY

Date 9/26/18

Exhibit B-2 Budget
Amendment #1

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis
(Name of RFP)

Budget Period: State Fiscal Year (SFY) 2019, July 1, 2018 - September 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	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,625.00	$ 476.13	$ 2,101.13
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ 568.75	$ 166.64	$ 735.39
3. Consultants	$ 26,774.00	$ 7,844.78	$ 34,618.78	$ -	$ -	$ -	$ 8,428.00	$ 2,469.40	$ 10,897.40
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,409.97	$ 413.12	$ 1,823.09
6. Travel	$ 560.53	$ 164.24	$ 724.77	$ -	$ -	$ -	$ 878.91	$ 257.52	$ 1,136.43
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 27,334.53	$ 8,009.02	$ 35,343.55	$ -	$ -	$ -	$ 12,910.63	$ 3,782.81	$ 16,693.44

Indirect As A Percent of Direct: 29.30%

Contractors Initials EDM

Date 7/28/18

Exhibit B-3 Budget
Amendment #1

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis
(Name of RFP)

Budget Period: State Fiscal Year (SFY) 2019, October 1, 2018 - June 30, 2019

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ 82,979.30	$ 24,312.93	$ 107,292.23	$ -	$ -	$ -	$ 82,700.00	$ 24,231.10	$ 106,931.10
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ (59.97)	$ (17.57)	$ (77.54)	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 1,564.92	$ 458.52	$ 2,023.44	$ -	$ -	$ -	$ 1,564.92	$ 458.52	$ 2,023.44
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ 3,450.21	$ 1,010.91	$ 4,461.12	$ -	$ -	$ -	$ 3,669.54	$ 1,075.18	$ 4,744.72
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 87,934.46	$ 25,764.80	$ 113,699.26	$ -	$ -	$ -	$ 87,934.46	$ 25,764.80	$ 113,699.26

Indirect As A Percent of Direct 29.30%

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

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 8th day of May A.D. 2017.

William M. Gardner
Secretary of State

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

CERTIFICATE OF VOTE/AUTHORITY

I, Anne-Lee Verville, 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 28 day of September.

Anne-Lee Verville, Board Chair

STATE OF NH
COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 28th day of September, 20[illegible] by Anne-Lee Verville.

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

Notary Public
My Commission Expires: April 19, 2022

CERTIFICATE OF INSURANCE

DATE: 09/25/2018

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

INSURED
Mary Hitchcock Memorial Hospital – DH-H
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

This is to certify that the Policy listed below have been issued to the Named Insured 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. This policy issued by a risk retention group may not be subject to all insurance laws and regulations in all states. State insurance insolvency funds are not available to a risk retention group policy.

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002018-A	07/01/2018	06/30/2019	EACH OCCURRENCE	$1,000,000
					PRODUCTS-COMP/OP AGGREGATE	
X	CLAIMS MADE				PERSONAL ADV INJURY	
					GENERAL AGGREGATE	$3,000,000
	OCCURRENCE				FIRE DAMAGE	
OTHER					MEDICAL EXPENSES	
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

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

Certificate of Insurance issued as evidence of insurance.

CERTIFICATE HOLDER

DHHS
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 DMCDONALD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 09/25/2018

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
100 Central Street, Suite 201
Holliston, MA 01746

CONTACT NAME: Dan McDonald
PHONE (A/C, No, Ext): (508) 808-7293
FAX (A/C, No): (866) 235-7129
E-MAIL ADDRESS: dan.mcdonald@hubinternational.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Safety National Casualty Corporation	15105
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Dartmouth-Hitchcock Health
1 Medical Center Dr.
Lebanon, NH 03756

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 Y/N; ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH); If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AGC4059104	07/01/2018	07/01/2019	X PER STATUTE; OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Evidence of Workers Compensation coverage for Mary Hitchcock Memorial Hospital

CERTIFICATE HOLDER
NH DHHS
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

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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

Consolidated Financial Statements
June 30, 2017 and 2016

Dartmouth-Hitchcock Health and Subsidiaries
Index
June 30, 2017 and 2016

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Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and Subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2017 and 2016, and the related consolidated statements of operations, changes in net assets and cash flows for the years then ended.

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 did not audit the financial statements of Alice Peck Day Hospital, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 2.8% of consolidated total assets at June 30, 2017, and total revenues of 3.3% of consolidated total revenues for the year then ended. We did not audit the consolidated financial statements of The Cheshire Medical Center, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 8.8% of consolidated total assets at June 30, 2016, and total revenues of 9.2% of consolidated total revenues for the year then ended. Those statements were audited by other auditors whose reports thereon have been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Alice Peck Day Hospital as of and for the year ended June 30, 2017 and The Cheshire Medical Center as of and for the year ended June 30, 2016, is based solely on the reports of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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

PricewaterhouseCoopers LLP, 101 Seaport Boulevard, Suite 500, Boston, MA 02210
T: (617) 530 5000, F: (617) 530 5001, www.pwc.com/us

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, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of June 30, 2017 and 2016, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were 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 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.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 17, 2017

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2017 and 2016

(in thousands of dollars)	2017	2016
Assets		
Current assets		
Cash and cash equivalents	$ 68,498	$ 40,592
Patient accounts receivable, net of estimated uncollectibles of $121,340 and $118,403 at June 30, 2017 and 2016 (Note 4)	237,260	260,988
Prepaid expenses and other current assets	89,203	95,820
Total current assets	394,961	397,400
Assets limited as to use (Notes 5 and 7)	662,323	592,468
Other investments for restricted activities (Notes 5 and 7)	124,529	142,036
Property, plant, and equipment, net (Note 6)	609,975	612,564
Other assets	97,120	87,266
Total assets	$ 1,888,908	$ 1,831,734
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 18,357	$ 18,307
Line of credit (Note 13)	-	36,550
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,220	3,176
Accounts payable and accrued expenses (Note 13)	89,160	107,544
Accrued compensation and related benefits	114,911	103,554
Estimated third-party settlements (Note 4)	27,433	19,650
Total current liabilities	253,081	288,781
Long-term debt, excluding current portion (Note 10)	616,403	625,341
Insurance deposits and related liabilities (Note 12)	50,960	56,887
Interest rate swaps (Notes 7 and 10)	20,916	28,917
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	282,971	272,493
Other liabilities	90,548	69,811
Total liabilities	1,314,879	1,342,230
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Unrestricted (Note 9)	424,947	360,183
Temporarily restricted (Notes 8 and 9)	94,917	75,731
Permanently restricted (Notes 8 and 9)	54,165	53,590
Total net assets	574,029	489,504
Total liabilities and net assets	$ 1,888,908	$ 1,831,734

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, 2017 and 2016

(in thousands of dollars)	2017	2016
Unrestricted revenue and other support		
Net patient service revenue, net of contractual allowances and discounts	$ 1,859,192	$ 1,689,275
Provision for bad debts	63,645	55,121
Net patient service revenue less provision for bad debts	1,795,547	1,634,154
Contracted revenue (Note 2)	43,671	65,982
Other operating revenue (Note 2 and 5)	119,177	82,352
Net assets released from restrictions	11,122	9,219
Total unrestricted revenue and other support	1,969,517	1,791,707
Operating expenses		
Salaries	966,352	872,465
Employee benefits	244,855	234,407
Medical supplies and medications	306,080	309,814
Purchased services and other	289,805	255,141
Medicaid enhancement tax (Note 4)	65,069	58,565
Depreciation and amortization	84,562	80,994
Interest (Note 10)	19,838	19,301
Total operating expenses	1,976,561	1,830,687
Operating loss	(7,044)	(38,980)
Nonoperating gains (losses)		
Investment gains (losses) (Notes 5 and 10)	51,056	(20,103)
Other losses	(4,153)	(3,845)
Contribution revenue from acquisition (Note 3)	20,215	18,083
Total nonoperating gains (losses), net	67,118	(5,865)
Excess (deficiency) of revenue over expenses	$ 60,074	$ (44,845)

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, 2017 and 2016

(in thousands of dollars)	**2017**	**2016**
Unrestricted net assets		
Excess (deficiency) of revenue over expenses	$ 60,074	$ (44,845)
Net assets released from restrictions	1,839	3,248
Change in funded status of pension and other postretirement benefits (Note 11)	(1,587)	(66,541)
Other changes in net assets	(3,364)	-
Change in fair value of interest rate swaps (Note 10)	7,802	(5,873)
Increase (decrease) in unrestricted net assets	64,764	(114,011)
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	26,592	12,227
Investment gains	1,677	518
Change in net unrealized gains on investments	3,775	(1,674)
Net assets released from restrictions	(12,961)	(12,467)
Contribution of temporarily restricted net assets from acquisition	103	670
Increase (decrease) in temporarily restricted net assets	19,186	(726)
Permanently restricted net assets		
Gifts and bequests	300	699
Investment gains (losses) in beneficial interest in trust	245	(219)
Contribution of permanently restricted net assets from acquisition	30	29
Increase in permanently restricted net assets	575	509
Change in net assets	84,525	(114,228)
Net assets		
Beginning of year	489,504	603,732
End of year	$ 574,029	$ 489,504

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, 2017 and 2016

(in thousands of dollars)		2017		2016
Cash flows from operating activities				
Change in net assets	$	84,525	$	(114,228)
Adjustments to reconcile change in net assets to net cash (used) provided by operating and nonoperating activities				
Change in fair value of interest rate swaps		(8,001)		4,177
Provision for bad debt		63,645		55,121
Depreciation and amortization		84,711		81,138
Contribution revenue from acquisition		(20,348)		(18,782)
Change in funded status of pension and other postretirement benefits		1,587		66,541
Loss on disposal of fixed assets		1,703		2,895
Net realized (gain) losses and change in net unrealized (gain) losses on investments		(57,255)		27,573
Restricted contributions and investment earnings		(4,374)		(4,301)
Proceeds from sales of securities		809		496
Loss from debt defeasance		381		-
Changes in assets and liabilities				
Patient accounts receivable, net		(35,811)		(101,567)
Prepaid expenses and other current assets		7,386		4,767
Other assets, net		(8,934)		2,188
Accounts payable and accrued expenses		(17,820)		(23,668)
Accrued compensation and related benefits		10,349		5,343
Estimated third-party settlements		7,783		(3,652)
Insurance deposits and related liabilities		(5,927)		(14,589)
Liability for pension and other postretirement benefits		8,935		15,599
Other liabilities		11,431		2,109
Net cash provided (used) by operating and nonoperating activities		124,775		(12,840)
Cash flows from investing activities				
Purchase of property, plant, and equipment		(77,361)		(73,021)
Proceeds from sale of property, plant, and equipment		1,087		612
Purchases of investments		(259,201)		(67,117)
Proceeds from maturities and sales of investments		276,934		66,105
Cash received through acquisition		3,564		12,619
Net cash used by investing activities		(54,977)		(60,802)
Cash flows from financing activities				
Proceeds from line of credit		65,000		140,600
Payments on line of credit		(101,550)		(105,250)
Repayment of long-term debt		(48,506)		(104,343)
Proceeds from issuance of debt		39,064		140,031
Payment of debt issuance costs		(274)		(14)
Restricted contributions and investment earnings		4,374		4,301
Net cash (used) provided by financing activities		(41,892)		75,325
Increase in cash and cash equivalents		27,906		1,683
Cash and cash equivalents				
Beginning of year		40,592		38,909
End of year	$	68,498	$	40,592
Supplemental cash flow information				
Interest paid	$	23,407	$	22,298
Asset depreciation due to affiliations		-		(960)
Net assets acquired as part of acquisition, net of cash aquired		16,784		6,163
Building construction in process financed by a third party		8,426		-
Construction in progress included in accounts payable and accrued expenses		14,669		16,427
Equipment acquired through issuance of capital lease obligations		-		2,001
Donated securities		809		688

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 Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC) (collectively referred to as "Dartmouth-Hitchcock" (D-H)), New London Hospital Association (NLH), Mt. Ascutney Hospital and Health Center (MAHHC), The Cheshire Medical Center (Cheshire), Alice Peck Day Memorial Hospital (APD) and Visiting Nurse & Hospice for VT and NH (VNH).

The "Health System" consists of D-HH, its affiliates 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 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, MHMH, DHC, NLH, Cheshire, and APD are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC and VNH are VT not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the IRC.

Fiscal year 2017 includes a full year of operations of D-HH, D-H, NLH, MAHHC, Cheshire, APD and VNH. Fiscal year 2016 includes a full year of operations of D-HH, D-H, NLH, MAHHC and Cheshire, four months of operations of APD and no activity for VNH.

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.

The Health System files annual Community Benefits Reports with the State of NH which outlines the community and charitable benefits it 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 lectures, 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.).

- *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 to participate 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.

- *Community health-related initiatives* occur outside of the organization(s) through various financial contributions of cash, in-kind, and grants to local organizations.

- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address 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 (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2017 and 2016, the Health System provided financial assistance to patients in the amount of approximately $29,934,000 and $30,637,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2017 and 2016 was approximately $12,173,000 and $12,257,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.

- *Government-sponsored healthcare services* are provided to Medicaid and Medicare patients at reimbursement levels that are significantly below the cost of the care provided.

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2016 was approximately $124,371,000. The 2017 Community Benefits Reports are expected to be filed in February 2018.

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, 2016:

(Unaudited, in thousands of dollars)

Government-sponsored healthcare services	$ 281,014
Health professional education	32,561
Subsidized health services	25,846
Charity care	10,769
Community health services	5,701
Research	3,417
Financial contributions	1,792
Community building activities	1,789
Community benefit operations	1,107
Total community benefit value	$ 363,996

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2017 and 2016, the Health System reported a provision for bad debt expense of approximately $63,645,000 and $55,121,000, respectively.

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* (ASC 954), which addresses the accounting for healthcare entities. In accordance with the provisions of ASC 954, net assets, revenue, expenses, gains and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, unrestricted net assets are amounts not subject to donor-imposed stipulations and are available for operations. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have 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 the allowance for estimated uncollectible accounts and contractual allowances, valuation of certain investments, estimated third-party settlements, insurance reserves, and pension obligations. Actual results may differ from those estimates.

Excess (Deficiency) of Revenue over Expenses
The consolidated statements of operations and changes in net assets include the excess (deficiency) of revenue over expenses. Operating revenues consist of those items attributable to the care of patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

Changes in unrestricted net assets which are excluded from the excess (deficiency) 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 and Provision for Bad Debts
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. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts 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).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt expense. 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. This revenue includes retail pharmacy, joint operating agreements, grant revenue, cafeteria sales, meaningful use incentive payments 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/comingled 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 (deficiency) 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 (deficiency) 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 affiliates 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 restricted assets 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 unrestricted investments, change in value of equity method investments, interest, and dividends) are included in the excess (deficiency) 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 unrestricted support, and excluded from the excess (deficiency) 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 depreciation and amortization in the consolidated statements of operations and changes in net assets using the straight-line method which approximates the effective interest method.

Trade Names
The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names 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 $2,700,000 as intangible assets associated with its affiliations as of June 30, 2017 and 2016. There were no impairment charges recorded for the years ended June 30, 2017 and 2016.

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 unrestricted net assets 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 (deficiency) 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 (deficiency) of revenue over expenses.

Gifts and Bequests
Unrestricted gifts and bequests 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 as either temporarily or permanently restricted 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, temporarily restricted net assets are reclassified as unrestricted net assets 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 Financial Accounting Standards Board (FASB) issued ASU 2014-09 - *Revenue from Contracts with Customers* at the conclusion of a joint effort with the International Accounting Standards Board to create common revenue recognition guidance in accordance with accounting principles generally accepted in the United States of America and international accounting standards. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services, by allocating transaction price to identified performance obligations, and recognizing that revenue as performance obligations are satisfied. Qualitative and quantitative disclosures will be required to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The original standard was effective for fiscal years beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

In April 2015, the FASB issued ASU 2015-03 - *Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs*, which requires all costs incurred to issue debt to be presented in the balance sheet as a direct deduction from the carrying value of the associated debt liability. The Health System implemented the new standard during the year ended June 30, 2017 and reclassified $3,933,000 as of June 30, 2016, to conform to the 2017 presentation.

In February 2016, the FASB issued ASU 2016-02 - *Leases*, 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. Early adoption is permitted once ASU 2014-09 has been adopted. 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) may be early adopted. The Health System implemented this aspect of the new standard 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*, which makes targeted changes to the not-for-profit financial reporting model. Under the new ASU, net asset reporting will be streamlined and clarified. The existing three-category classification of net assets will be replaced with a simplified model that combines temporarily

restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property, plant, and equipment have also been simplified and clarified. New disclosures will highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. Not-for-profits will continue to have flexibility to decide whether to report an operating subtotal and if so, to self-define what is included or excluded. However, transparent disclosure must be provided if the operating subtotal includes internal transfers made by the governing board. The ASU also imposes several new requirements related to reporting expenses, including providing information about expenses by their natural classification. The ASU is effective for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System and early adoption is permitted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

Reclassifications
Certain amounts in the 2016 consolidated financial statements have been reclassified to conform to the 2017 presentation.

3. Acquisitions

Effective July 1, 2016, D-HH became the sole corporate member of VNH through an affiliation agreement. VNH is a not-for-profit corporation organized in VT providing home health, hospice and community based services to residents of NH and VT.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, The Health System recorded contribution income of approximately $20,348,000, reflecting the fair value of the contributed net assets of VNH, on the transaction date. Of this amount $20,215,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statement of operations. Restricted contribution income of $103,000 and $30,000 was recorded within temporarily and permanently restricted net assets, respectively in the accompanying consolidated statement of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs were expensed as incurred.

The fair value of assets, liabilities, and net assets contributed by VNH at July 1, 2016 were as follows:

(in thousands of dollars)

Assets		
Cash and cash equivalents	$	3,564
Patient accounts receivable, net		4,107
Property, plant, and equipment, net		436
Other assets		15,323
Total assets acquired	$	23,430
Liabilities		
Accounts payable and accrued expenses	$	1,194
Accrued compensation and related benefits		1,008
Other liabilities		880
Total liabilities assumed		3,082
Net Assets		
Unrestricted		20,215
Temporarily restricted		103
Permanently restricted		30
Total net assets		20,348
Total liabilities and net assets	$	23,430

A summary of the financial results of VNH included in the consolidated statement of operations and changes in net assets for the period from the date of acquisition (July 1, 2016) through June 30, 2017 is as follows:

(in thousands of dollars)

Total operating revenues	$	22,964
Total operating expenses		22,707
Operating gain		257
Nonoperating gains		2,604
Excess of revenue over expenses		2,861
Net assets transferred to affiliate		20,348
Changes in temporarily and permanently restricted net assets		(103)
Increase in net assets	$	23,106

A summary of the consolidated financial results of the Health System for the year ended June 30, 2016 as if the transaction had occurred on July 1, 2015 are as follows (unaudited):

(in thousands of dollars)	
Total operating revenues	$ 1,813,935
Total operating expenses	1,852,896
Operating loss	(38,961)
Nonoperating gains	(5,953)
(Deficiency) of revenue over expenses	(44,914)
Net assets released from restriction used for capital purchases	3,248
Change in funded status of pension and other post retirement benefits	(66,541)
Other changes in net assets	-
Change in fair value on interest rate swaps	(5,873)
(Decrease) increase in unrestricted net assets	$ (114,080)

4. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debts as follows for the years ended June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Gross patient service revenue	$ 4,865,332	$ 4,426,305
Less: Contractual allowances	3,006,140	2,737,030
Provision for bad debt	63,645	55,121
Net patient service revenue	$ 1,795,547	$ 1,634,154

Accounts receivable are reduced by an allowance for estimated uncollectibles. In evaluating the collectability of accounts receivable, the Health System analyzes past collection history and identifies trends for several categories of self-pay accounts (uninsured, residual balances, pre-collection accounts and charity) to estimate the appropriate allowance percentages in establishing the allowance for bad debt expense. Management performs collection rate look-back analyses on a quarterly basis to evaluate the sufficiency of the allowance for estimated uncollectibles. Throughout the year, after all reasonable collection efforts have been exhausted, the difference between the standard rates and the amounts actually collected, including contractual adjustments and uninsured discounts, will be written off against the allowance for estimated uncollectibles. In addition to the review of the categories of revenue, management monitors the write offs against established allowances as of a point in time to determine the appropriateness of the underlying assumptions used in estimating the allowance for estimated uncollectibles.

Accounts receivable, prior to adjustment for estimated uncollectibles, are summarized as follows at June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Receivables		
Patients	$ 90,786	$ 126,320
Third-party payors	263,240	244,716
Nonpatient	4,574	8,355
	$ 358,600	$ 379,391

The allowance for estimated uncollectibles is $121,340,000 and $118,403,000 as of June 30, 2017 and 2016.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2017 and 2016:

	2017	2016
Medicare	43 %	42 %
Anthem/blue cross	18	19
Commercial insurance	20	22
Medicaid	13	14
Self-pay/other	6	3
	100 %	100 %

The Health System has agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the years ended June 30, 2017 and 2016 with major third-party payors follows:

Medicare
The Health System's inpatient acute care services provided to Medicare program beneficiaries are paid at prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is 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. Under the system, outpatient services are reimbursed based on a pre-determined amount for each outpatient procedure, subject to various mandated modifications. The Health System is reimbursed during the year for services to Medicare beneficiaries based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subsequent audit of this report by the Medicare fiscal intermediary.

Certain of the Health System's affiliates qualify as Critical Access Hospitals (CAH), which are reimbursed by Medicare at 101% (subject to sequestration of 2%) of reasonable costs for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. Medicare reimburses nursing home and rehabilitation services based on an acuity driven prospective payment system with no retrospective settlement.

Medicaid
The Health System's payments for inpatient services rendered to NH Medicaid beneficiaries are based on a prospective payment system, while outpatient services are reimbursed on a retrospective cost basis or fee schedules. NH Medicaid Outpatient Direct Medical Education costs are reimbursed, as a pass-through, based on the filing of the Medicare cost report. Payment for inpatient and outpatient services rendered to VT Medicaid beneficiaries are based on prospective payment systems and the skilled nursing facility is reimbursed on a prospectively determined per diem rate.

During the years ended June 30, 2017 and 2016, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $65,069,000 and $58,565,000, respectively. The taxes are calculated at 5.4% for NH and 6% for VT of certain net patient 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.

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 $645,000 and $528,000 in 2017 and 2016, 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 "SB 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 Medicaid Enhancement Tax Agreement effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the years ended June 30, 2017 and 2016, the Health System received disproportionate share hospital (DSH) payments of approximately $59,473,000 and $56,718,000, respectively which is included in net patient service revenue in the consolidated statement of operations and changes in net assets.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers. The Health System has recognized other revenue of $1,156,000 and $2,330,000 in meaningful use incentives for both the Medicare and VT Medicaid programs during the years ended June 30, 2017 and 2016, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action; failure to comply with such laws and regulations can result in fines, penalties and exclusion from the Medicare and Medicaid programs.

Other
For services provided to patients with commercial insurance, the Health System receives payment for inpatient services at prospectively determined rates-per-discharge, prospectively determined per diem rates or a percentage of established charges. Outpatient services are reimbursed on a fee schedule or at a discount from established charges.

Nonacute and physician services are paid at various rates under different arrangements with governmental payors, commercial insurance carriers and health maintenance organizations. The basis for payments under these arrangements includes prospectively determined per visit rates, discounts from established charges, fee schedules, and reasonable cost subject to limitations.

The Health System has provided for its estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2011 - 2015). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2017 and 2016, changes in prior estimates related to the Health System's settlements with third-party payors resulted in increases (decreases) in net patient service revenue of $2,000,000 and $(859,000) respectively, in the consolidated statements of operations and changes in net assets.

5. Investments

The composition of investments at June 30, 2017 and 2016 is set forth in the following table:

(in thousands of dollars)	2017	2016
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 9,923	$ 12,915
U.S. government securities	44,835	33,578
Domestic corporate debt securities	100,953	65,610
Global debt securities	105,920	119,385
Domestic equities	129,548	100,009
International equities	95,167	61,768
Emerging markets equities	33,893	34,282
Real Estate Investment Trust	791	432
Private equity funds	39,699	33,209
Hedge funds	30,448	52,337
	591,177	513,525
Investments held by captive insurance companies (Note 12)		
U.S. government securities	18,814	22,484
Domestic corporate debt securities	21,681	29,123
Global debt securities	5,707	5,655
Domestic equities	9,048	7,830
International equities	13,888	11,901
	69,138	76,993
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	2,008	1,950
Total assets limited as to use	$ 662,323	$ 592,468

(in thousands of dollars)	2017	2016
Other investments for restricted activities		
Cash and short-term investments	$ 5,467	$ 12,219
U.S. government securities	28,096	21,351
Domestic corporate debt securities	27,762	33,203
Global debt securities	14,560	20,808
Domestic equities	18,451	19,215
International equities	15,499	13,986
Emerging markets equities	3,249	4,887
Real Estate Investment Trust	790	470
Private equity funds	3,949	4,780
Hedge funds	6,676	11,087
Other	30	30
Total other investments for restricted activities	$ 124,529	$ 142,036

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 when debt securities or equity securities 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, 2017 and 2016. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

(in thousands of dollars)		2017	
	Fair Value	Equity	Total
Cash and short-term investments	$ 17,398	$ -	$ 17,398
U.S. government securities	91,745	-	91,745
Domestic corporate debt securities	121,631	28,765	150,396
Global debt securities	45,660	80,527	126,187
Domestic equities	144,618	12,429	157,047
International equities	29,910	94,644	124,554
Emerging markets equities	1,226	35,916	37,142
Real Estate Investment Trust	128	1,453	1,581
Private equity funds	-	43,648	43,648
Hedge funds	-	37,124	37,124
Other	30	-	30
	$ 452,346	$ 334,506	$ 786,852

(in thousands of dollars)	2016 Fair Value	Equity	Total
Cash and short-term investments	$ 27,084	$ -	$ 27,084
U.S. government securities	77,413	-	77,413
Domestic corporate debt securities	101,271	26,665	127,936
Global debt securities	40,356	105,492	145,848
Domestic equities	115,082	11,972	127,054
International equities	23,271	64,384	87,655
Emerging markets equities	331	38,838	39,169
Real estate investment trust	20	882	902
Private equity funds	-	37,989	37,989
Hedge funds	-	63,424	63,424
Other	30	-	30
	$ 384,858	$ 349,646	$ 734,504

Investment income (losses) is comprised of the following for the years ended June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Unrestricted		
Interest and dividend income, net	$ 4,418	$ 5,088
Net realized gains (losses) on sales of securities	16,868	(1,223)
Change in net unrealized gains on investments	30,809	(22,980)
	52,095	(19,115)
Temporarily restricted		
Interest and dividend income, net	1,394	536
Net realized gains (losses) on sales of securities	283	(18)
Change in net unrealized gains on investments	3,775	(1,674)
	5,452	(1,156)
Permanently restricted		
Change in net unrealized gains (losses) on beneficial interest in trust	245	(219)
	245	(219)
	$ 57,792	$ (20,490)

For the years ended June 30, 2017 and 2016 unrestricted investment income (losses) is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $1,039,000 and $988,000 and as nonoperating gains (losses) of approximately $51,056,000 and ($20,103,000), 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, 2017 and 2016, the Health System has committed to contribute approximately $119,719,000 and

$116,851,000 to such funds, of which the Health System has contributed approximately $81,982,000 and $80,019,000 and has outstanding commitments of $37,737,000 and $36,832,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Land	$ 38,058	$ 33,004
Land improvements	37,579	36,899
Buildings and improvements	818,831	801,840
Equipment	766,667	744,443
Equipment under capital leases	20,495	20,823
	1,681,630	1,637,009
Less: Accumulated depreciation and amortization	1,101,058	1,046,617
Total depreciable assets, net	580,572	590,392
Construction in progress	29,403	22,172
	$ 609,975	$ 612,564

As of June 30, 2017 construction in progress primarily consists of the construction of the Hospice & Palliative Care Center and APD's medical office building, both in Lebanon, NH. The estimated cost to complete these projects at June 30, 2017 is $7,335,000 and $9,381,000, respectively.

The construction in progress for the Borwell building reported as of June 30, 2016 was completed during the first quarter of fiscal year 2017 and the building addition for New London at the Newport Health Center was completed in the second quarter of fiscal year 2017.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $84,711,000 and $81,138,000 for 2017 and 2016, 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).

Interest Rate Swaps
The fair value of interest rate swaps, are determined using the present value of the fixed and floating legs of the swaps. Each series of cash flows are discounted by observable market interest rate curves and credit risk.

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 management 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, 2017 and 2016:

	2017					
(in thousands of dollars)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Redemption or Liquidation**	**Days' Notice**
Assets						
Investments						
Cash and short term investments	$ 17,398	$ -	$ -	$ 17,398	Daily	1
U.S. government securities	91,745	-	-	91,745	Daily	1
Domestic corporate debt securities	66,238	55,393	-	121,631	Daily–Monthly	1–15
Global debt securities	28,142	17,518	-	45,660	Daily–Monthly	1–15
Domestic equities	144,618	-	-	144,618	Daily–Monthly	1–10
International equities	29,870	40	-	29,910	Daily–Monthly	1–11
Emerging market equities	1,226	-	-	1,226	Daily–Monthly	1–7
Real estate investment trust	128	-	-	128	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	379,365	72,981	-	452,346		
Deferred compensation plan assets						
Cash and short-term investments	2,633	-	-	2,633		
U.S. government securities	37	-	-	37		
Domestic corporate debt securities	8,802	-	-	8,802		
Global debt securities	1,095	-	-	1,095		
Domestic equities	28,609	-	-	28,609		
International equities	9,595	-	-	9,595		
Emerging market equities	2,706	-	-	2,706		
Real estate	2,112	-	-	2,112		
Multi strategy fund	13,083	-	-	13,083		
Guaranteed contract	-	-	83	83		
Total deferred compensation plan assets	68,672	-	83	68,755	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,244	9,244	Not applicable	Not applicable
Total assets	$ 448,037	$ 72,981	$ 9,327	$ 530,345		
Liabilities						
Interest rate swaps	$ -	$ 20,916	$ -	$ 20,916	Not applicable	Not applicable
Total liabilities	$ -	$ 20,916	$ -	$ 20,916		

(in thousands of dollars)	2016 Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 27,084	$ -	$ -	$ 27,084	Daily	1
U.S. government securities	77,413	-	-	77,413	Daily	1
Domestic corporate debt securities	27,626	73,645	-	101,271	Daily–Monthly	1–15
Global debt securities	23,103	17,253	-	40,356	Daily–Monthly	1–15
Domestic equities	115,082	-	-	115,082	Daily–Monthly	1–10
International equities	23,271	-	-	23,271	Daily–Monthly	1–11
Emerging market equities	331	-	-	331	Daily–Monthly	1–7
Real estate investment trust	20	-	-	20	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	293,930	90,928	-	384,858		
Deferred compensation plan assets						
Cash and short-term investments	2,478	-	-	2,478		
U.S. government securities	30	-	-	30		
Domestic corporate debt securities	6,710	-	-	6,710		
Global debt securities	794	-	-	794		
Domestic equities	23,502	-	-	23,502		
International equities	8,619	-	-	8,619		
Emerging market equities	2,113	-	-	2,113		
Real estate	2,057	-	-	2,057		
Multi strategy fund	9,188	-	-	9,188		
Guaranteed contract	-	-	80	80		
Total deferred compensation plan assets	55,491	-	80	55,571	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,087	9,087	Not applicable	Not applicable
Total assets	$ 349,421	$ 90,928	$ 9,167	$ 449,516		
Liabilities						
Interest rate swaps	$ -	$ 28,917	$ -	$ 28,917	Not applicable	Not applicable
Total liabilities	$ -	$ 28,917	$ -	$ 28,917		

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

(in thousands of dollars)	2017 Beneficial Interest in Perpetual Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 9,087	$ 80	$ 9,167
Purchases	-	-	-
Sales	-	-	-
Net unrealized gains (losses)	157	3	160
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,244	$ 83	$ 9,327

	2016		
(in thousands of dollars)	**Beneficial Interest in Perpetual Trust**	**Guaranteed Contract**	**Total**
Balances at beginning of year	$ 9,345	$ 78	$ 9,423
Purchases	-	-	-
Sales	-	-	-
Net unrealized gains (losses)	(258)	2	(256)
Net asset transfer from affiliate	-	-	-
Balances at end of year	$ 9,087	$ 80	$ 9,167

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, 2017 and 2016.

8. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2017 and 2016:

(in thousands of dollars)	**2017**	**2016**
Healthcare services	$ 32,583	$ 44,561
Research	25,385	16,680
Purchase of equipment	3,080	2,826
Charity care	13,814	1,543
Health education	17,489	8,518
Other	2,566	1,603
	$ 94,917	$ 75,731

Permanently restricted net assets consist of the following at June 30, 2017 and 2016:

(in thousands of dollars)	**2017**	**2016**
Healthcare services	$ 22,916	$ 32,105
Research	7,795	7,767
Purchase of equipment	6,274	5,266
Charity care	6,895	2,991
Health education	10,228	5,408
Other	57	53
	$ 54,165	$ 53,590

Income earned on permanently restricted net assets 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 classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, 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.

Unrestricted net assets 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. Temporarily restricted net assets 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 temporary restrictions on these funds have been met, the funds are reclassified to unrestricted net assets.

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, 2017 and 2016.

Endowment net asset composition by type of fund consists of the following at June 30, 2017 and 2016:

(in thousands of dollars)	2017 Unrestricted	2017 Temporarily Restricted	2017 Permanently Restricted	2017 Total
Donor-restricted endowment funds	$ -	$ 29,701	$ 45,756	$ 75,457
Board-designated endowment funds	26,389	-	-	26,389
Total endowed net assets	$ 26,389	$ 29,701	$ 45,756	$ 101,846

(in thousands of dollars)	2016 Unrestricted	2016 Temporarily Restricted	2016 Permanently Restricted	2016 Total
Donor-restricted endowment funds	$ -	$ 25,780	$ 45,402	$ 71,182
Board-designated endowment funds	26,205	-	-	26,205
Total endowed net assets	$ 26,205	$ 25,780	$ 45,402	$ 97,387

Changes in endowment net assets for the year ended June 30, 2017:

(in thousands of dollars)	2017 Unrestricted	2017 Temporarily Restricted	2017 Permanently Restricted	2017 Total
Balances at beginning of year	$ 26,205	$ 25,780	$ 45,402	$ 97,387
Net investment return	283	5,285	2	5,570
Contributions	-	210	300	510
Transfers	-	(26)	22	(4)
Release of appropriated funds	(99)	(1,548)	-	(1,647)
Net asset transfer from affiliates	-	-	30	30
Balances at end of year	$ 26,389	$ 29,701	45,756	$ 101,846
Balances at end of year			45,756	
Beneficial interest in perpetual trust			8,409	
Permanently restricted net assets			$ 54,165	

Changes in endowment net assets for the year ended June 30, 2016:

	2016			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Balances at beginning of year	$ 26,405	$ 28,296	$ 44,491	$ 99,192
Net investment return	(54)	(1,477)	3	(1,528)
Contributions	-	271	699	970
Transfers	-	(216)	180	(36)
Release of appropriated funds	(146)	(1,094)	-	(1,240)
Net asset transfer from affiliates	-	-	29	29
Balances at end of year	$ 26,205	$ 25,780	45,402	$ 97,387

Balances at end of year	45,402
Beneficial interest in perpetual trust	8,188
Permanently restricted net assets	$ 53,590

10. Long-Term Debt

A summary of long-term debt at June 30, 2017 and 2016 is as follows:

(in thousands of dollars)	2017	2016
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2015A, principal maturing in varying annual amounts, through August 2031 (2)	$ 82,975	$ 86,710
Series 2013, principal maturing in varying annual amounts, through August 2043 (10)	-	19,230
Vermont Educational and Health Buildings Financing Agency (VEHFBA) Revenue Bonds		
Series 2010A, principal maturing in varying annual amounts, through August 2030 (11)	-	7,881
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2016A, principal maturing in varying annual amounts, through August 2046 (1)	24,608	-
Series 2016B, principal maturing in varying annual amounts, through August 2046 (1)	10,970	-
Series 2014A, principal maturing in varying annual amounts, through August 2022 (4)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (4)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (5)	71,700	72,720
Series 2012B, principal maturing in varying annual amounts, through August 2031 (5)	39,340	39,900
Series 2012, principal maturing in varying annual amounts, through July 2039 (9)	26,735	27,490
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)	75,000	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (8)	57,540	63,370
Total variable and fixed rate debt	430,358	433,791

A summary of long-term debt at June 30, 2017 and 2016 is as follows (continued):

(in thousands of dollars)	2017	2016
Other		
Revolving Line of Credit, principal maturing through March 2019 (3)	49,750	49,750
Series 2012, principal maturing in varying annual amounts, through July 2025 (6)	136,000	140,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)*	15,900	16,287
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment*	811	313
Note payable to a financial institution due in monthly interest only payments from October 2011 through September 2012, and monthly installments from October 2012 through 2016, including principal and interest at 3.25%; collateralized by savings account*	-	2,952
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*	437	494
Mortgage note payable to the US Dept of Agriculture; monthly payments of $10,892 include interest of 2.375% through November 2046*	2,763	-
Obligations under capital leases	3,435	4,875
Total other debt	209,096	214,671
Total variable and fixed rate debt	430,358	433,791
Total long-term debt	639,454	648,462
Less		
Original issue discount, net	862	881
Bond issuance costs, net	3,832	3,933
Current portion	18,357	18,307
	$ 616,403	$ 625,341

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)	2017
2018	$ 18,357
2019	68,279
2020	19,401
2021	19,448
2022	19,833
Thereafter	494,136
	$ 639,454

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 MHMH, DHC, Cheshire, NLH and MAHHC. 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 of which are the Annual Debt Service Coverage Ratio (1.10x) and the Days Cash on Hand Ratio (> 75 days).

(1) Series 2016A and 2016B Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2016A and 2016B in July 2016 through a private placement with a financial institution. The Series 2016A Revenue Bonds were primarily used to refund Series 2013A and Series 2013B and the Series 2016B Revenue Bonds were used to finance 2016 projects. The Series 2016A Revenue Bonds mature in variable amounts through 2046. Interest is equal to the sum of .70 times one month LIBOR plus .70 times the spread. The variable rate as of June 30 2017 was 1.48% The Series 2016B is fixed with an interest rate of 1.78% and matures at various dates through 2046.

(2) Series 2015A Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds and to cover cost of issuance. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30 2017 was 1.51%

(3) Revolving Line of Credit

Through the DHOG, entered into Revolving Line of Credit TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The variable rate as of June 30 2017 was 1.63%

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

Through 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.

(5) Series 2012A and 2012B Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2012A and Series 2012B in November 2012. The proceeds from the Series 2012A and 2012B were used to advance refund the Series 2002 Revenue Bonds and to cover cost of issuance. Interest on the 2012A Revenue Bonds is fixed with an interest rate of 2.29% and matures at various dates through 2031. Interest on the Series 2012B Revenue Bonds is fixed with an interest rate of 2.33% and matures at various dates through 2031.

(6) Series 2012 Bank Loan

Through the DHOG, issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2025.

(7) Series 2010 Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2010, in June 2010. The proceeds from the Series 2010 Revenue Bonds were primarily used to construct a 140,000 square foot ambulatory care facility in Nashua, NH as well as various equipment. Interest on the bonds accrue at a fixed rate of 5.00% and mature at various dates through August 2040.

(8) Series 2009 Revenue Bonds

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 5.00% and 6.00% and mature at various dates through August 2038.

(9) Series 2012 Revenue Bonds

Issued through the NHHEFA $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 are collateralized by an interest in its gross receipts under the terms of the bond agreement. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%). Principal is payable in annual installments ranging from $780,000 to $1,750,000 through July 2039.

(10) Series 2013 Revenue Bonds

Issued through the NHHEFA $15,520,000 tax exempt Revenue Bonds Series 2013A. The Series 2013A funds were used to refund Series 2007 Revenue Bonds. Additional borrowings were obtained (up to $9,480,000 Revenue Bonds, Series 2013B) for the construction of a new health center building in Newport, NH. The bonds are collateralized by the gross receipts and property. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times the Adjusted LIBOR Rate plus .72 times the credit spread rate. As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with

respect to the Series 2007 Revenue Bonds but remains in effect. These bonds were paid with the proceeds of the Series 2016A Revenue Bonds.

(11) Series 2010A Revenue Bonds

Issued through the VEHBFA $9,244,000 of Revenue Bonds Series 2010A. The funds were used to refund 2004 and 2005 Series A Bonds. The bonds are collateralized by gross receipts. The bonds shall bear interest at the one-month LIBOR rate plus 3.50%, multiplied by 6% adjusting monthly. The bonds were purchased by TD Bank on March 1, 2010. Principal payments began on April 1, 2010 for a period of 20 years ranging in amounts from $228,000 in 2014 to $207,000 in 2030. These bonds were refunded in July 2016.

Outstanding joint and several indebtedness of the DHOG at June 30, 2017 and 2016 approximates $616,108,000 and $568,940,000, respectively.

Non Obligated Group Bonds

(12) Series 2010 Revenue Bonds

Issued through the Business Finance Authority (BFA) of the State of NH. 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. APD may prepay certain of these bonds according to the terms of the loan and trust agreement. The bonds are redeemable at any time by APD at par value plus any accrued interest. The bonds are also subject to optional tender for purchase (as a whole) in November 2020 at par plus accrued interest.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $2,008,000 and $1,950,000 at June 30, 2017 and 2016, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets.

For the years ended June 30, 2017 and 2016 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 $19,838,000 and $19,301,000 and is included in other nonoperating losses of $3,135,000 and $3,201,000, 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.

A summary of the Health System's derivative financial instruments is as follows:

- A Fixed Payor Swap designed as a cash flow hedge of the NHHEFA Series 2011 Revenue Bonds. The Swap had an initial notional amount of $91,040,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 4.56% in exchange for the counterparty's payment of 67% of USD-LIBOR-BBA. The Swap's term matches that of the

associated bonds. The 2011 interest rate swap was not integrated with the 2011 bonds. When the 2011 bonds were refinanced, the swap became associated with the 2015 bond.

- An Interest Rate Swap to hedge the interest rate risk associated with the NHHEFA Series 2013 Revenue Bonds. The Swap had an initial notional amount of $15,000,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 3.94% in exchange for the counterparty's payment at 67% of USD-LIBOR-BBA. The Swap term matches that of the associated bonds.

- An Interest Rate Swap to hedge the interest rate risk associated with the VEHFBA Series 2010A Revenue Bonds. The Swap had an initial notional amount of $7,244,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 2.41% in exchange for the counterparty's payment of 69% of USD-LIBOR-BBA. The swap was terminated in September 2016, while the bonds will remain outstanding until 2030.

The obligation of the Health System to make payments on its bonds with respect to interest is in no way conditional upon the Health System's receipt of payments from the interest rate swap agreement counterparty.

At June 30, 2017 and 2016 the fair value of the Health System's interest rate swaps was a liability of $20,915,000 and $28,917,000, respectively. The change in fair value during the years ended June 30, 2017 and 2016 was a (decrease) and an increase of ($8,002,000) and $4,177,000, respectively. For the years ended June 30, 2017 and 2016 the Health System recognized a nonoperating gain of $124,000 and $1,696,000 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 affiliates 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 or had been approved by the applicable Board of Trustees to be frozen by December 31, 2017.

In December of 2016 the Board of Trustees approved to accelerate the freeze date on the remaining pension plan from December 31, 2017 to January 31, 2017. Effective with that date, the last of the participants earning benefits in any of the Health System's defined benefit plans will no longer earn benefits under the 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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Service cost for benefits earned during the year	$ 5,736	$ 11,084
Interest cost on projected benefit obligation	47,316	48,036
Expected return on plan assets	(64,169)	(63,479)
Net prior service cost	109	848
Net loss amortization	20,267	26,098
Special/contractural termination benefits	119	300
One-time benefit upon plan freeze acceleration	9,519	-
	$ 18,897	$ 22,887

The following assumptions were used to determine net periodic pension expense as of June 30, 2017 and 2016:

	2017	2016
Discount rate	4.20 % – 4.90 %	4.30 % – 4.90%
Rate of increase in compensation	Age Graded - N/A	Age Graded/0.00 % - 2.50 %
Expected long-term rate of return on plan assets	7.50 % – 7.75 %	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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Change in benefit obligation		
Benefit obligation at beginning of year	$ 1,096,619	$ 988,143
Service cost	5,736	11,084
Interest cost	47,316	48,108
Benefits paid	(43,276)	(39,001)
Expenses paid	(183)	(180)
Actuarial (gain) loss	6,884	99,040
Settlements	-	(13,520)
Plan change	-	2,645
Special/contractual termination benefits	-	300
One-time benefit upon plan freeze acceleration	9,519	-
Benefit obligation at end of year	1,122,615	1,096,619
Change in plan assets		
Fair value of plan assets at beginning of year	872,320	845,052
Actual return on plan assets	44,763	81,210
Benefits paid	(43,276)	(42,494)
Expenses paid	(183)	(180)
Employer contributions	5,077	2,252
Settlements	-	(13,520)
Fair value of plan assets at end of year	878,701	872,320
Funded status of the plans	(243,914)	(224,299)
Less current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(243,868)	(224,253)
Liability for pension	$ (243,914)	$ (224,299)

For the years ended June 30, 2017 and 2016 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 unrestricted net assets as of June 30, 2017 and 2016 are as follows:

(in thousands of dollars)	2017	2016
Net actuarial loss	$ 429,782	$ 423,640
Prior service cost	-	228
	$ 429,782	$ 423,868

The estimated amounts to be amortized from unrestricted net assets into net periodic pension expense in 2018 for net actuarial losses is $10,966,000.

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,123,010,000 and $1,082,818,000 at June 30, 2016 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2017 and 2016:

	2017	2016
Discount rate	4.00 % – 4.30 %	4.20 % – 4.30 %
Rate of increase in compensation	N/A - 0.00 %	Age Graded/0.00 % - 2.50 %

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 June 30, 2017 and 2016, it is expected that the LDI strategy will hedge approximately 55% and 65%, respectively, 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	0–5	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, 2017 and 2016:

	2017					
(in thousands of dollars)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Redemption or Liquidation**	**Days' Notice**
Investments						
Cash and short-term investments	$ 23	$ 29,792	$ -	$ 29,815	Daily	1
U.S. government securities	7,875	-	-	7,875	Daily–Monthly	1–15
Domestic debt securities	140,498	243,427	-	383,925	Daily–Monthly	1–15
Global debt securities	426	90,389	-	90,815	Daily–Monthly	1–15
Domestic equities	154,597	16,938	-	171,535	Daily–Monthly	1–10
International equities	9,837	93,950	-	103,787	Daily–Monthly	1–11
Emerging market equities	2,141	45,351	-	47,492	Daily–Monthly	1–17
REIT funds	362	2,492	-	2,854	Daily–Monthly	1–17
Private equity funds	-	-	96	96	See Note 7	See Note 7
Hedge funds	-	-	40,507	40,507	Quarterly–Annual	60–96
Total investments	$ 315,759	$ 522,339	$ 40,603	$ 878,701		

	2016					
(in thousands of dollars)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Redemption or Liquidation**	**Days' Notice**
Investments						
Cash and short-term investments	$ 5,463	$ 10,879	$ -	$ 16,342	Daily	1
U.S. government securities	4,177	-	-	4,177	Daily–Monthly	1–15
Domestic debt securities	95,130	296,362	-	391,492	Daily–Monthly	1–15
Global debt securities	409	88,589	-	88,998	Daily–Monthly	1–15
Domestic equities	148,998	15,896	-	164,894	Daily–Monthly	1–10
International equities	12,849	77,299	-	90,148	Daily–Monthly	1–11
Emerging market equities	352	37,848	-	38,200	Daily–Monthly	1–17
REIT funds	356	1,465	-	1,821	Daily–Monthly	1–17
Private equity funds	-	-	255	255	See Note 7	See Note 7
Hedge funds	-	37,005	38,988	75,993	Quarterly–Annual	60–96
Total investments	$ 267,734	$ 565,343	$ 39,243	$ 872,320		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2017 and 2016:

	2017		
(in thousands of dollars)	**Hedge Funds**	**Private Equity Funds**	**Total**
Balances at beginning of year	$ 38,988	$ 255	$ 39,243
Transfers	-	-	-
Purchases	-	-	-
Sales	(880)	(132)	(1,012)
Net realized (losses) gains	33	36	69
Net unrealized gains	2,366	(63)	2,303
Balances at end of year	$ 40,507	$ 96	$ 40,603

	2016		
(in thousands of dollars)	**Hedge Funds**	**Private Equity Funds**	**Total**
Balances at beginning of year	$ 42,076	$ 437	$ 42,513
Transfers	-	-	-
Purchases	-	-	-
Sales	(468)	(142)	(610)
Net realized (losses) gains	(55)	155	100
Net unrealized gains	(2,565)	(195)	(2,760)
Balances at end of year	$ 38,988	$ 255	$ 39,243

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2017 and 2016 were approximately $7,965,000 and $8,808,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2017 and 2016.

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, 2017 and 2016.

The weighted average asset allocation for the Health System's Plans at June 30, 2017 and 2016 by asset category is as follows:

	2017	2016
Cash and short-term investments	3 %	2 %
U.S. government securities	1	1
Domestic debt securities	44	45
Global debt securities	10	10
Domestic equities	20	19
International equities	12	10
Emerging market equities	5	4
Hedge funds	5	9
	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 $5,047,000 to the Plans in 2018 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)

2018	$ 46,313
2019	48,689
2020	51,465
2021	54,375
2022	57,085
2023 – 2027	323,288

Defined Contribution Plans

The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, 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 $33,375,000 and $29,416,000 in 2017 and 2016, 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 affiliate and plan. No employer contributions were made to any of these plans in 2017 and 2016 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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Service cost	$ 448	$ 544
Interest cost	2,041	2,295
Net prior service income	(5,974)	(5,974)
Net loss amortization	689	610
	$ (2,796)	$ (2,525)

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, 2017 and 2016:

(in thousands of dollars)	2017	2016
Change in benefit obligation		
Benefit obligation at beginning of year	$ 51,370	$ 50,438
Service cost	448	544
Interest cost	2,041	2,295
Benefits paid	(3,211)	(3,277)
Actuarial (gain) loss	(8,337)	1,404
Employer contributions	(34)	(34)
Benefit obligation at end of year	42,277	51,370
Funded status of the plans	(42,277)	(51,370)
Current portion of liability for postretirement medical and life benefits	(3,174)	(3,130)
Long term portion of liability for postretirement medical and life benefits	(39,103)	(48,240)
Liability for postretirement medical and life benefits	$ (42,277)	$ (51,370)

For the years ended June 30, 2017 and 2016 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 unrestricted net assets are as follows:

(in thousands of dollars)	2017	2016
Net prior service income	$ (21,504)	$ (27,478)
Net actuarial loss	2,054	11,080
	$ (19,450)	$ (16,398)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in 2018 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, 2017 and thereafter:

(in thousands of dollars)	
2018	$ 3,174
2019	3,149
2020	3,142
2021	3,117
2022	3,113
2023-2027	14,623

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.20% in 2017 and an assumed healthcare cost trend rate of 6.75%, trending down to 4.75% in 2021 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, 2017 and 2016 by $1,067,000 and $4,685,000 and the net periodic postretirement medical benefit cost for the years then ended by $110,000 and $284,000, 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, 2017 and 2016 by $974,000 and $3,884,000 and the net periodic postretirement medical benefit cost for the years then ended by $96,000 and $234,000, respectively.

12. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College, Cheshire, NLH and MAHHC 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. 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. D-H 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.

APD is covered for malpractice claims under a modified claims-made policy purchased through New England Alliance for Health (NEAH). While APD remains in the current insurance program under this policy, the coverage year is based on the date the claim is filed; subject to a medical incident arising after the retroactive date (includes prior acts). The policy provides modified claims-made coverage for former insured providers for claims that relate to the employee's period of

employment at APD and for services that were provided within the scope of the employee's duties. Therefore, when the employee leaves the corporation, tail coverage is not required.

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2017 and 2016 are summarized as follows:

	2017		
(in thousands of dollars)	**HAC** *(audited)*	**RRG** *(unaudited)*	**Total**
Assets	$ 76,185	$ 2,055	$ 78,240
Shareholders' equity	13,620	801	14,421
Net income	-	(5)	(5)

	2016		
(in thousands of dollars)	**HAC** *(audited)*	**RRG** *(unaudited)*	**Total**
Assets	$ 86,101	$ 2,237	$ 88,338
Shareholders' equity	13,620	806	14,426
Net income	-	50	50

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 $15,802,000 and $10,571,000 for the years ended June 30, 2017 and 2016, respectively. Minimum future lease payments under noncancelable operating leases at June 30, 2017 were as follows:

(in thousands of dollars)	
2018	$ 8,370
2019	6,226
2020	3,928
2021	3,105
2022	1,518
Thereafter	367
	$ 23,514

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 $85,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire March 1, 2018. There was no outstanding balance under the lines of credit at June 30, 2017. The Health System had outstanding balances under the lines of credits in the amount of $36,550,000 at June 30, 2016. Interest expense was approximately $915,000 and $551,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2017 and 2016:

(in thousands of dollars)	2017	2016
Program services	$ 1,662,413	$ 1,553,377
Management and general	311,820	271,409
Fundraising	2,328	5,901
	$ 1,976,561	$ 1,830,687

15. Subsequent Events

The Health System has assessed the impact of subsequent events through November 17, 2017, 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.

Consolidating Supplemental Information - Unaudited

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2017

(in thousands of dollars)	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	$ 27,328	$ 10,645	$ 7,797	$ 6,662	$ -	$ 52,432	$ 16,066	$ -	$ 68,498
Patient accounts receivable, net	193,733	17,723	8,539	4,659	-	224,654	12,606	-	237,260
Prepaid expenses and other current assets	93,816	6,945	3,650	1,351	(16,585)	89,177	8,034	(8,008)	89,203
Total current assets	314,877	35,313	19,986	12,672	(16,585)	366,263	36,706	(8,008)	394,961
Assets limited as to use	580,254	19,104	11,784	9,058	-	620,200	42,123	-	662,323
Other investments for restricted activities	86,398	4,764	2,833	6,079	-	100,074	24,455	-	124,529
Property, plant, and equipment, net	448,743	64,933	43,264	17,167	-	574,107	35,868	-	609,975
Other assets	89,650	2,543	5,965	4,095	(11,520)	90,733	27,674	(21,287)	97,120
Total assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ 16,034	$ 780	$ 737	$ 80	$ -	$ 17,631	$ 726	$ -	$ 18,357
Line of credit	-	-	-	550	(550)	-	-	-	-
Current portion of liability for pension and other postretirement plan benefits	3,220	-	-	-	-	3,220	-	-	3,220
Accounts payable and accrued expenses	72,362	19,715	5,356	2,854	(16,585)	83,702	13,466	(8,008)	89,160
Accrued compensation and related benefits	99,638	5,428	2,335	3,448	-	110,849	4,062	-	114,911
Estimated third-party settlements	11,322	-	7,265	1,915	-	20,502	6,931	-	27,433
Total current liabilities	202,576	25,923	15,693	8,847	(17,135)	235,904	25,185	(8,008)	253,081
Long-term debt, excluding current portion	545,100	26,185	26,402	10,976	(10,970)	597,693	18,710	-	616,403
Insurance deposits and related liabilities	50,960	-	-	-	-	50,960	-	-	50,960
Interest rate swaps	17,606	-	3,310	-	-	20,916	-	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion	267,409	8,761	-	6,801	-	282,971	-	-	282,971
Other liabilities	77,622	2,636	1,426	-	-	81,684	8,864	-	90,548
Total liabilities	1,161,273	63,505	46,831	26,624	(28,105)	1,270,128	52,759	(8,008)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	258,887	58,250	32,504	15,247	-	364,888	81,344	(21,285)	424,947
Temporarily restricted	68,473	4,902	345	1,363	-	75,083	19,836	(2)	94,917
Permanently restricted	31,289	-	4,152	5,837	-	41,278	12,887	-	54,165
Total net assets	358,649	63,152	37,001	22,447	-	481,249	114,067	(21,287)	574,029
Total liabilities and net assets	$ 1,519,922	$ 126,657	$ 83,832	$ 49,071	$ (28,105)	$ 1,751,377	$ 166,826	$ (29,295)	$ 1,888,908

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2017

(in thousands of dollars)	D-HH (Parent)	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	$ 1,166	$ 27,760	$ 11,601	$ 8,280	$ 6,988	$ 8,129	$ 4,594	$ -	$ 68,498
Patient accounts receivable, net	-	193,733	17,723	8,539	4,681	8,878	3,706	-	237,260
Prepaid expenses and other current assets	3,884	94,305	5,899	3,671	1,340	4,179	518	(24,593)	89,203
Total current assets	5,050	315,798	35,223	20,490	12,989	21,186	8,818	(24,593)	394,961
Assets limited as to use	-	596,904	19,104	11,782	9,889	8,168	16,476	-	662,323
Other investments for restricted activities	6	94,210	21,204	2,833	6,079	197	-	-	124,529
Property, plant, and equipment, net	50	451,418	68,921	43,751	18,935	23,447	3,453	-	609,975
Other assets	23,866	89,819	8,586	5,378	1,812	283	183	(32,807)	97,120
Total assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 16,034	$ 780	$ 737	$ 137	$ 603	$ 66	$ -	$ 18,357
Line of credit	-	-	-	-	550	-	-	(550)	-
Current portion of liability for pension and other postretirement plan benefits	-	3,220	-	-	-	-	-	-	3,220
Accounts payable and accrued expenses	5,996	72,806	19,718	5,365	2,946	5,048	1,874	(24,593)	89,160
Accrued compensation and related benefits	-	99,638	5,428	2,335	3,480	2,998	1,032	-	114,911
Estimated third-party settlements	6,165	11,322	-	7,265	1,915	766	-	-	27,433
Total current liabilities	12,161	203,020	25,926	15,702	9,028	9,415	2,972	(25,143)	253,081
Long-term debt, excluding current portion	-	545,100	26,185	26,402	11,356	15,633	2,697	(10,970)	616,403
Insurance deposits and related liabilities	-	50,960	-	-	-	-	-	-	50,960
Interest rate swaps	-	17,606	-	3,310	-	-	-	-	20,916
Liability for pension and other postretirement plan benefits, excluding current portion	-	267,409	8,761	-	6,801	-	-	-	282,971
Other liabilities	-	77,622	2,531	1,426	-	8,969	-	-	90,548
Total liabilities	12,161	1,161,717	63,403	46,840	27,185	34,017	5,669	(36,113)	1,314,879
Commitments and contingencies									
Net assets									
Unrestricted	16,367	278,695	60,758	32,897	15,319	18,965	23,231	(21,285)	424,947
Temporarily restricted	444	74,304	18,198	345	1,363	265	-	(2)	94,917
Permanently restricted	-	33,433	10,679	4,152	5,837	34	30	-	54,165
Total net assets	16,811	386,432	89,635	37,394	22,519	19,264	23,261	(21,287)	574,029
Total liabilities and net assets	$ 28,972	$ 1,548,149	$ 153,038	$ 84,234	$ 49,704	$ 53,281	$ 28,930	$ (57,400)	$ 1,888,908

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	Dartmouth-Hitchcock	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets					
Current assets					
Cash and cash equivalents	$ 1,535	$ 1,535	$ 39,057	$ -	$ 40,592
Patient accounts receivable, net	220,173	220,173	40,815	-	260,988
Prepaid expenses and other current assets	95,158	95,158	23,595	(22,933)	95,820
Total current assets	316,866	316,866	103,467	(22,933)	397,400
Assets limited as to use	551,724	551,724	40,744	-	592,468
Other investments for restricted activities	91,879	91,879	50,157	-	142,036
Property, plant, and equipment, net	454,894	454,894	157,670	-	612,564
Other assets	65,613	65,613	36,582	(14,929)	87,266
Total assets	$ 1,480,976	$ 1,480,976	$ 388,620	$ (37,862)	$ 1,831,734
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,638	$ 15,638	$ 2,669	$ -	$ 18,307
Line of Credit	35,000	35,000	1,550	-	36,550
Current portion of liability for pension and other postretirement plan benefits	3,176	3,176	-	-	3,176
Accounts payable and accrued expenses	87,373	87,373	43,104	(22,933)	107,544
Accrued compensation and related benefits	86,997	86,997	16,557	-	103,554
Estimated third-party settlements	21,434	21,434	(1,784)	-	19,650
Total current liabilities	249,618	249,618	62,096	(22,933)	288,781
Long-term debt, excluding current portion	550,090	550,090	75,251	-	625,341
Insurance deposits and related liabilities	56,887	56,887	-	-	56,887
Interest rate swaps	24,148	24,148	4,769	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	246,816	246,816	25,677	-	272,493
Other liabilities	54,218	54,218	15,593	-	69,811
Total liabilities	1,181,777	1,181,777	183,386	(22,933)	1,342,230
Commitments and contingencies					
Net assets					
Unrestricted	217,033	217,033	158,079	(14,929)	360,183
Temporarily restricted	51,173	51,173	24,558	-	75,731
Permanently restricted	30,993	30,993	22,597	-	53,590
Total net assets	299,199	299,199	205,234	(14,929)	489,504
Total liabilities and net assets	$ 1,480,976	$ 1,480,976	$ 388,620	$ (37,862)	$ 1,831,734

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Assets								
Current assets								
Cash and cash equivalents	$ 607	$ 2,066	$ 16,640	$ 6,699	$ 5,388	$ 9,192	$ -	$ 40,592
Patient accounts receivable, net	-	220,173	17,836	7,377	5,347	10,255	-	260,988
Prepaid expenses and other current assets	7,463	95,738	5,458	3,209	2,022	4,863	(22,933)	95,820
Total current assets	8,070	317,977	39,934	17,285	12,757	24,310	(22,933)	397,400
Assets limited as to use	-	551,724	17,525	10,345	8,260	4,614	-	592,468
Other investments for restricted activities	217	114,719	18,486	2,843	5,742	29	-	142,036
Property, plant, and equipment, net	76	457,570	75,591	43,204	19,659	16,464	-	612,564
Other assets	17,950	65,782	9,496	5,028	3,929	10	(14,929)	87,266
Total assets	$ 26,313	$ 1,507,772	$ 161,032	$ 78,705	$ 50,347	$ 45,427	$ (37,862)	$ 1,831,734
Liabilities and Net Assets								
Current liabilities								
Current portion of long-term debt	$ -	$ 15,638	$ 755	$ 941	$ 466	$ 507	$ -	$ 18,307
Line of credit	-	35,000	-	-	1,550	-	-	36,550
Current portion of liability for pension and other postretirement plan benefits	-	3,176	-	-	-	-	-	3,176
Accounts payable and accrued expenses	9,857	88,557	15,866	6,791	4,589	4,817	(22,933)	107,544
Accrued compensation and related benefits	-	86,997	7,728	2,052	3,128	3,649	-	103,554
Estimated third-party settlements	-	10,534	1,569	5,206	917	1,424	-	19,650
Total current liabilities	9,857	239,902	25,918	14,990	10,650	10,397	(22,933)	288,781
Long-term debt, excluding current portion	-	550,090	26,985	20,767	11,145	16,354	-	625,341
Insurance deposits and related liabilities	-	56,887	-	-	-	-	-	56,887
Interest rate swaps	-	24,148	-	4,646	123	-	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	-	246,816	18,662	-	7,015	-	-	272,493
Other liabilities	-	65,118	3,522	1,135	-	36	-	69,811
Total liabilities	9,857	1,182,961	75,087	41,538	28,933	26,787	(22,933)	1,342,230
Commitments and contingencies								
Net assets								
Unrestricted	16,456	234,609	58,978	32,706	14,099	18,264	(14,929)	360,183
Temporarily restricted	-	57,091	16,454	345	1,496	345	-	75,731
Permanently restricted	-	33,111	10,513	4,116	5,819	31	-	53,590
Total net assets	16,456	324,811	85,945	37,167	21,414	18,640	(14,929)	489,504
Total liabilities and net assets	$ 26,313	$ 1,507,772	$ 161,032	$ 78,705	$ 50,347	$ 45,427	$ (37,862)	$ 1,831,734

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2017

(in thousands of dollars)	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
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ (19)	$ 1,770,207	$ 88,985	$ -	$ 1,859,192
Provisions for bad debts	42,963	14,125	2,010	1,705	-	60,803	2,842	-	63,645
Net patient service revenue less provisions for bad debts	1,404,998	200,140	57,918	46,367	(19)	1,709,404	86,143	-	1,795,547
Contracted revenue	88,620	-	-	1,861	(41,771)	48,710	(4,995)	(44)	43,671
Other operating revenue	104,611	3,045	3,839	1,592	(1,148)	111,939	6,418	820	119,177
Net assets released from restrictions	9,550	639	116	61	-	10,366	756	-	11,122
Total unrestricted revenue and other support	1,607,779	203,824	61,873	49,881	(42,938)	1,880,419	88,322	776	1,969,517
Operating expenses									
Salaries	787,644	102,769	30,311	23,549	(21,784)	922,489	42,327	1,536	966,352
Employee benefits	202,178	26,632	7,071	5,523	(5,322)	236,082	8,392	381	244,855
Medical supplies and medications	257,100	30,692	6,143	2,905	(273)	296,567	9,513	-	306,080
Purchased services and other	208,671	28,068	12,795	13,224	(17,325)	245,433	45,331	(959)	289,805
Medicaid enhancement tax	50,118	7,800	2,923	1,620	-	62,461	2,608	-	65,069
Depreciation and amortization	66,067	10,238	3,881	2,138	-	82,324	2,238	-	84,562
Interest	17,352	1,127	819	249	(209)	19,338	500	-	19,838
Total operating expenses	1,589,130	207,326	63,943	49,208	(44,913)	1,864,694	110,909	958	1,976,561
Operating margin (loss)	18,649	(3,502)	(2,070)	673	1,975	15,725	(22,587)	(182)	(7,044)
Nonoperating gains (losses)									
Investment gains (losses)	42,484	1,378	1,570	984	(209)	46,207	4,849	-	51,056
Other, net	(3,003)	-	(879)	570	(1,767)	(5,079)	740	186	(4,153)
Contribution revenue from acquisition	-	-	-	-	-	-	20,215	-	20,215
Total nonoperating gains, net	39,481	1,378	691	1,554	(1,976)	41,128	25,804	186	67,118
Excess (deficiency) of revenue over expenses	58,130	(2,124)	(1,379)	2,227	(1)	56,853	3,217	4	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 8)	983	-	9	442	-	1,434	405	-	1,839
Change in funded status of pension and other postretirement benefits	(5,297)	4,031	-	(321)	-	(1,587)	-	-	(1,587)
Net assets transferred (from) to affiliates	(18,380)	900	143	986	-	(16,351)	16,351	-	-
Other changes in net assets	-	-	-	(2,286)	-	(2,286)	5,281	(6,359)	(3,364)
Change in fair value on interest rate swaps	6,418	-	1,337	47	-	7,802	-	-	7,802
Increase (decrease) in unrestricted net assets	$ 41,854	$ 2,807	$ 110	$ 1,095	$ (1)	$ 45,865	$ 25,254	$ (6,355)	$ 64,764

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2017

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support									
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,447,961	$ 214,265	$ 59,928	$ 48,072	$ 65,835	$ 23,150	$ (19)	$ 1,859,192
Provisions for bad debts	-	42,963	14,125	2,010	1,705	2,275	567	-	63,645
Net patient service revenue less provisions for bad debts	-	1,404,998	200,140	57,918	46,367	63,560	22,583	(19)	1,795,547
Contracted revenue	(5,802)	89,427	-	-	1,861	-	-	(41,815)	43,671
Other operating revenue	673	106,775	3,264	3,837	3,038	1,537	381	(328)	119,177
Net assets released from restrictions	-	10,200	639	116	61	106	-	-	11,122
Total unrestricted revenue and other support	(5,129)	1,611,400	204,043	61,871	51,327	65,203	22,964	(42,162)	1,969,517
Operating expenses									
Salaries	1,009	787,644	102,769	30,311	24,273	29,397	11,197	(20,248)	966,352
Employee benefits	293	202,178	26,632	7,071	5,686	5,532	2,404	(4,941)	244,855
Medical supplies and medications	-	257,100	30,692	6,143	2,905	7,760	1,753	(273)	306,080
Purchased services and other	16,021	212,414	29,902	12,653	13,626	16,564	6,907	(18,282)	289,805
Medicaid enhancement tax	-	50,118	7,800	2,923	1,620	2,608	-	-	65,069
Depreciation and amortization	26	66,067	10,396	3,886	2,242	1,532	413	-	84,562
Interest	-	17,352	1,127	819	249	467	33	(209)	19,838
Total operating expenses	17,349	1,592,873	209,318	63,806	50,601	63,860	22,707	(43,953)	1,976,561
Operating (loss) margin	(22,478)	18,527	(5,275)	(1,935)	726	1,343	257	1,791	(7,044)
Nonoperating gains (losses)									
Investment (losses) gains	(321)	44,746	2,124	1,516	1,045	439	1,716	(209)	51,056
Other, net	-	(3,003)	-	(879)	581	(161)	888	(1,579)	(4,153)
Contribution revenue from acquisition	20,215	-	-	-	-	-	-	-	20,215
Total nonoperating gains, net	19,894	41,743	2,124	637	1,626	278	2,604	(1,788)	67,118
(Deficiency) excess of revenue over expenses	(2,584)	60,270	(3,151)	(1,298)	2,352	1,621	2,861	3	60,074
Unrestricted net assets									
Net assets released from restrictions (Note 8)	-	1,075	-	9	442	158	155	-	1,839
Change in funded status of pension and other postretirement benefits	-	(5,297)	4,031	-	(321)	-	-	-	(1,587)
Net assets transferred (from) to affiliates	(3,864)	(18,380)	900	143	986	-	20,215	-	-
Additional paid in capital		-		-	-	-	-		-
Other changes in net assets	6,359	-	-	-	(2,286)	(1,078)	-	(6,359)	(3,364)
Change in fair value on interest rate swaps	-	6,418	-	1,337	47	-	-	-	7,802
(Decrease) increase in unrestricted net assets	$ (89)	$ 44,086	$ 1,780	$ 191	$ 1,220	$ 701	$ 23,231	$ (6,356)	$ 64,764

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	Dartmouth-Hitchcock	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Unrestricted revenue and other support					
Net patient service revenue, net of contractual allowances and discounts	$ 1,387,677	$ 1,387,677	$ 302,159	$ (561)	$ 1,689,275
Provisions for bad debts	41,072	41,072	14,049	-	55,121
Net patient service revenue less provisions for bad debts	$ 1,346,605	$ 1,346,605	$ 288,110	$ (561)	$ 1,634,154
Contracted revenue	63,188	63,188	2,794	-	65,982
Other operating revenue	69,902	69,902	16,994	(4,544)	82,352
Net assets released from restrictions	7,928	7,928	1,291	-	9,219
Total unrestricted revenue and other support	1,487,623	1,487,623	309,189	(5,105)	1,791,707
Operating expenses					
Salaries	731,721	731,721	126,108	14,636	872,465
Employee benefits	197,050	197,050	34,824	2,533	234,407
Medical supplies and medications	236,918	236,918	72,896	-	309,814
Purchased services and other	208,763	208,763	68,582	(22,204)	255,141
Medicaid enhancement tax	46,078	46,078	12,487	-	58,565
Depreciation and amortization	62,348	62,348	18,646	-	80,994
Interest	16,821	16,821	2,480	-	19,301
Total operating expenses	1,499,699	1,499,699	336,023	(5,035)	1,830,687
Operating (loss) margin	(12,076)	(12,076)	(26,834)	(70)	(38,980)
Nonoperating (losses) gains					
Investment losses	(18,537)	(18,537)	(1,566)	-	(20,103)
Other, net	(3,789)	(3,789)	(56)	-	(3,845)
Contribution revenue from acquisition	-	-	18,014	69	18,083
Total nonoperating (losses) gains, net	(22,326)	(22,326)	16,392	69	(5,865)
Deficiency of revenue over expenses	(34,402)	(34,402)	(10,442)	(1)	(44,845)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	1,994	1,994	1,254	-	3,248
Change in funded status of pension and other postretirement benefits	(52,262)	(52,262)	(14,279)	-	(66,541)
Net assets transferred (from) to affiliates	(22,558)	(22,558)	22,558	-	-
Additional paid in capital	-	-	12,793	(12,793)	-
Change in fair value on interest rate swaps	(4,907)	(4,907)	(966)	-	(5,873)
(Decrease) increase in unrestricted net assets	$ (112,135)	$ (112,135)	$ 10,918	$ (12,794)	$ (114,011)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Unrestricted revenue and other support								
Net patient service revenue, net of contractual allowances and discounts	$ -	$ 1,387,677	$ 171,620	$ 61,740	$ 47,680	$ 21,119	$ (561)	$ 1,689,275
Provisions for bad debts	-	41,072	9,833	1,951	1,249	1,016	-	55,121
Net patient service revenue less provisions for bad debts	-	1,346,605	161,787	59,789	46,431	20,103	(561)	1,634,154
Contracted revenue	1,696	64,286	-	-	-	-	-	65,982
Other operating revenue	3,300	71,475	3,187	3,509	4,555	870	(4,544)	82,352
Net assets released from restrictions	-	8,713	322	65	119	-	-	9,219
Total unrestricted revenue and other support	4,996	1,491,079	165,296	63,363	51,105	20,973	(5,105)	1,791,707
Operating expenses								
Salaries	730	732,393	60,406	29,873	24,019	10,408	14,636	872,465
Employee benefits	219	197,165	19,276	6,824	6,260	2,130	2,533	234,407
Medical supplies and medications	-	236,918	59,121	6,597	4,246	2,932	-	309,814
Purchased services and other	22,506	211,611	14,020	12,876	11,955	4,377	(22,204)	255,141
Medicaid enhancement tax	-	46,078	7,132	2,808	1,707	840	-	58,565
Depreciation and amortization	15	62,348	11,069	4,674	2,345	543	-	80,994
Interest	-	16,821	1,046	823	467	144	-	19,301
Total operating expenses	23,470	1,503,334	172,070	64,475	50,999	21,374	(5,035)	1,830,687
Operating (loss) margin	(18,474)	(12,255)	(6,774)	(1,112)	106	(401)	(70)	(38,980)
Nonoperating gains (losses)								
Investment (losses) gains	(1,027)	(18,848)	(1,075)	627	(15)	235	-	(20,103)
Other, net	(529)	(3,647)	-	57	205	-	69	(3,845)
Contribution revenue from acquisition	18,083	-	-	-	-	-	-	18,083
Total nonoperating (losses) gains, net	16,527	(22,495)	(1,075)	684	190	235	69	(5,865)
(Deficiency) excess of revenue over expenses	(1,947)	(34,750)	(7,849)	(428)	296	(166)	(1)	(44,845)
Unrestricted net assets								
Net assets released from restrictions (Note 8)	-	2,185	107	23	586	347	-	3,248
Change in funded status of pension and other postretirement benefits	-	(52,262)	(12,982)	-	(1,297)	-	-	(66,541)
Net assets transferred to (from) affiliates	4,475	(22,558)	-	-	-	18,083	-	-
Additional paid in capital	12,793	-	-	-	-	-	(12,793)	-
Change in fair value on interest rate swaps	-	(4,907)	-	(1,115)	149	-	-	(5,873)
Increase (decrease) in unrestricted net assets	$ 15,321	$ (112,292)	$ (20,724)	$ (1,520)	$ (266)	$ 18,264	$ (12,794)	$ (114,011)

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in unrestricted net assets of D-HH and subsidiaries. All intercompany accounts and transactions between D-HH and 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.

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2016 and 2015

Dartmouth-Hitchcock Health and Subsidiaries
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June 30, 2016 and 2015

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Report of Independent Auditors

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and Subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended.

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.

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the consolidated financial statements of The Cheshire Medical Center, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets of 8.8% and 9.7% of consolidated total assets at June 30, 2016 and 2015, respectively, and total revenues of 9.2% and 3.5%, respectively, of consolidated total revenues for the years then ended. Those statements were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for The Cheshire Medical Center, is based solely on the report of the other auditors. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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.

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Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of June 30, 2016 and 2015, and the results of its operations and changes in net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Our audits were 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 audits 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 operations and 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 and changes in net assets and cash flows of the individual companies.

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2016

PricewaterhouseCoopers LLP, 101 Seaport Boulevard, Suite 500, Boston, MA 02210
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Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
Years Ended June 30, 2016 and 2015

(in thousands of dollars)	2016	2015
Assets		
Current assets		
Cash and cash equivalents	$ 40,592	$ 38,909
Patient accounts receivable, net of estimated uncollectibles of $118,403 and $92,532 at June 30, 2016 and 2015 (Note 4)	260,988	204,272
Prepaid expenses and other current assets	95,820	100,586
Total current assets	397,400	343,767
Assets limited as to use (Notes 5, 7, and 10)	592,468	620,425
Other investments for restricted activities (Notes 5 and 7)	142,036	132,016
Property, plant, and equipment, net (Note 6)	612,564	601,355
Other assets	91,199	88,450
Total assets	$ 1,835,667	$ 1,786,013
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 18,307	$ 17,179
Line of credit (Note 13)	36,550	1,200
Current portion of liability for pension and other postretirement plan benefits (Note 11)	3,176	3,249
Accounts payable and accrued expenses (Note 13)	107,544	120,221
Accrued compensation and related benefits	103,554	94,864
Estimated third-party settlements (Note 4)	30,550	36,599
Total current liabilities	299,681	273,312
Long-term debt, excluding current portion (Note 10)	629,274	575,484
Insurance deposits and related liabilities (Note 12)	56,887	62,356
Interest rate swaps (Notes 7 and 10)	28,917	24,740
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	272,493	190,280
Other liabilities	58,911	56,109
Total liabilities	1,346,163	1,182,281
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)		
Net assets		
Unrestricted (Note 9)	360,183	474,194
Temporarily restricted (Notes 8 and 9)	75,731	76,457
Permanently restricted (Notes 8 and 9)	53,590	53,081
Total net assets	489,504	603,732
Total liabilities and net assets	$ 1,835,667	$ 1,786,013

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, 2016 and 2015

(in thousands of dollars)	2016	2015
Unrestricted revenue and other support		
Net patient service revenue, net of provision for bad debt ($55,121 and $17,562 in 2016 and 2015), (Notes 1 and 4)	$ 1,634,154	$ 1,380,559
Contracted revenue (Note 2)	65,982	80,835
Other operating revenue (Note 2 and 5)	82,352	82,993
Net assets released from restrictions	9,219	15,637
Total unrestricted revenue and other support	1,791,707	1,560,024
Operating expenses		
Salaries	872,465	778,387
Employee benefits	234,407	214,627
Medical supplies and medications	309,814	219,967
Purchased services and other	255,141	218,704
Medicaid enhancement tax (Note 4)	58,565	51,996
Depreciation and amortization	80,994	67,213
Interest (Note 10)	19,301	18,442
Total operating expenses	1,830,687	1,569,336
Operating loss	(38,980)	(9,312)
Nonoperating gains (losses)		
Investment losses (Notes 5 and 10)	(20,103)	(11,015)
Other losses	(3,845)	(1,241)
Contribution revenue from acquisition (Note 3)	18,083	92,499
Total nonoperating (losses) gains, net	(5,865)	80,243
(Deficiency) excess of revenue over expenses	$ (44,845)	$ 70,931

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, 2016 and 2015

(in thousands of dollars)	2016	2015
Unrestricted net assets		
(Deficiency) excess of revenue over expenses	$ (44,845)	$ 70,931
Net assets released from restrictions	3,248	2,411
Change in funded status of pension and other postretirement benefits (Note 11)	(66,541)	(60,892)
Change in fair value of interest rate swaps (Note 10)	(5,873)	(931)
(Decrease) increase in unrestricted net assets	(114,011)	11,519
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	12,227	10,625
Investment gains	518	1,797
Change in net unrealized gains on investments	(1,674)	(1,619)
Net assets released from restrictions	(12,467)	(18,048)
Contribution of temporarily restricted net assets from acquisition	670	19,038
(Decrease) increase in temporarily restricted net assets	(726)	11,793
Permanently restricted net assets		
Gifts and bequests	699	389
Investment losses in beneficial interest in trust	(219)	(187)
Contribution of permanently restricted net assets from acquisition	29	16,610
Increase in permanently restricted net assets	509	16,812
Change in net assets	(114,228)	40,124
Net assets		
Beginning of year	603,732	563,608
End of year	$ 489,504	$ 603,732

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, 2016 and 2015

(in thousands of dollars)	2016	2015
Cash flows from operating activities		
Change in net assets	$ (114,228)	$ 40,124
Adjustments to reconcile change in net assets to net cash (used) provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	4,177	(104)
Provision for bad debt	55,121	17,562
Depreciation and amortization	81,138	67,414
Contribution revenue from acquisition	(18,782)	(128,147)
Change in funded status of pension and other postretirement benefits	66,541	60,892
Loss on disposal of fixed assets	2,895	670
Net realized losses and change in net unrealized losses on investments	27,573	15,795
Restricted contributions	(4,301)	(11,040)
Proceeds from sale of securities	496	723
Changes in assets and liabilities		
Patient accounts receivable, net	(101,567)	(17,151)
Prepaid expenses and other current assets	4,767	9,165
Other assets, net	2,188	(4,388)
Accounts payable and accrued expenses	(23,668)	(5,169)
Accrued compensation and related benefits	5,343	8,684
Estimated third-party settlements	(3,652)	2,637
Insurance deposits and related liabilities	(14,589)	(17,177)
Liability for pension and other postretirement benefits	15,599	(25,471)
Other liabilities	2,109	(669)
Net cash (used) provided by operating and nonoperating activities	(12,840)	14,350
Cash flows from investing activities		
Purchase of property, plant, and equipment	(73,021)	(87,196)
Proceeds from sale of property, plant, and equipment	612	1,533
Purchases of investments	(67,117)	(166,589)
Proceeds from maturities and sales of investments	66,105	195,950
Cash received through acquisition	12,619	29,914
Net cash used by investing activities	(60,802)	(26,388)
Cash flows from financing activities		
Proceeds from line of credit	140,600	60,904
Payments on line of credit	(105,250)	(60,700)
Repayment of long-term debt	(104,343)	(54,682)
Proceeds from issuance of debt	140,031	43,452
Payment of debt issuance costs	(14)	6
Restricted contributions	4,301	11,040
Net cash provided by financing activities	75,325	20
Increase (decrease) in cash and cash equivalents	1,683	(12,018)
Cash and cash equivalents		
Beginning of year	38,909	50,927
End of year	$ 40,592	$ 38,909
Supplemental cash flow information		
Interest paid	$ 22,298	$ 21,659
Asset (depreciation) appreciation due to affiliations	(960)	15,596
Construction in progress included in accounts payable and accrued expenses	16,427	12,259
Equipment acquired through issuance of capital lease obligations	2,001	1,741
Donated securities	688	685

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 Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC) (collectively referred to as "Dartmouth-Hitchcock" (D-H)), New London Hospital Association (NLH), MT. Ascutney Hospital and Health Center (MAHHC), The Cheshire Medical Center (Cheshire) and Alice Peck Day Health Systems Corp. (APD).

The "Health System" consists of D-HH, its affiliates and their subsidiaries.

D-HH 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. D-HH also operates four physician practices and a nursing home. D-HH 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, MHMH, DHC, NLH, Cheshire and APD are NH not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC is a VT not-for-profit corporation exempt from federal income taxes under Section 501(c)(3) of the IRC.

Fiscal year 2016 includes a full year of operations of D-HH, D-H, NLH, MAHHC, Cheshire and four months of operations of APD. Fiscal year 2015 includes a full year of operations of D-HH, D-H, NLH, MAHHC and four months of operations of Cheshire.

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.

The Health System files annual Community Benefits Reports with the State of NH which outlines the community and charitable benefits it provides. 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 lectures, 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.).

- *Subsidized health services* are services provided, 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.

- *Community health-related initiatives* occur outside of the organization(s) through various financial contributions of cash, in-kind, and grants to local organizations.

- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address 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 (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2016 and 2015, the Health System provided financial assistance to patients in the amount of approximately $30,637,000 and $50,076,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2016 and 2015 was approximately $12,257,000 and $18,401,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.

  Charity care provided by the Health System decreased by approximately $19,400,000 from 2015 to 2016. This change was due to the implementation of the Federal Exchange in December of 2013 and the NH Medicaid Expansion Plan in August of 2014. The Health System began to experience decreases in uninsured patients and increases in patients covered by the Federal Exchange NH in summer of calendar 2015 (fiscal year 2015) which continued to decrease as more NH uninsured and underinsured patients were able to receive coverage by the Federal or NH Medicaid plans specifically impacting fiscal 2016.

- *Government-sponsored healthcare services* are provided to Medicaid and Medicare patients at reimbursement levels that are significantly below the cost of the care provided.

- *The uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2015 was approximately $146,758,000. The 2016 Community Benefits Reports are expected to be filed in February 2017.

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, 2015:

(Unaudited, in thousands of dollars)

Community health services	$	4,373
Health professional education		30,157
Subsidized health services		13,645
Research		5,361
Financial contributions		5,829
Community building activities		623
Community benefit operations		582
Charity care		18,401
Government-sponsored healthcare services		258,189
Total community benefit value	$	337,160

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2016 and 2015, the Health System reported a provision for bad debt expense of approximately $55,121,000 and $17,562,000, respectively.

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* (ASC 954), which addresses the accounting for healthcare entities. In accordance with the provisions of ASC 954, net assets and revenue, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, unrestricted net assets are amounts not subject to donor-imposed stipulations and are available for operations. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have 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 date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. The most significant areas that are affected by the use of estimates include the allowance for estimated uncollectible accounts and contractual allowances, valuation of certain investments, estimated third-party settlements, insurance reserves, and pension obligations. Actual results may differ from those estimates.

(Deficiency) Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include (deficiency) excess of revenue over expenses. Operating revenues consist of those items attributable to the care of

patients, including contributions and investment income on unrestricted investments, which are utilized to provide charity and other operational support. Peripheral activities, including unrestricted contribution income from acquisitions, realized gains/losses on sales of investment securities and changes in unrealized gains/losses in investments are reported as nonoperating gains (losses).

Changes in unrestricted net assets which are excluded from (deficiency) 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 and Provision for Bad Debts
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. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts 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).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt expense. 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).

Contract Revenue
The Health System has various Professional Service Agreements (PSAs), pursuant to which certain facilities 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. This revenue includes retail pharmacy, joint operating agreements, grant revenue, cafeteria sales, meaningful use incentive payments 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/comingled 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 (deficiency) 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 (deficiency) 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 sheets date on a nondistressed basis.

Certain affiliates 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 restricted assets 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 unrestricted investments, change in value of equity method investments, interest, and dividends) are included in (deficiency) excess of revenue over expenses 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 market 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 unrestricted support, and excluded from (deficiency) 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 as other assets, are amortized over the term of the related bonds. Amortization is recorded within depreciation and amortization in the consolidated statements of operations and changes in net assets using the straight-line method which approximates the effective interest method.

Trade Names
The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names 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 $2,700,000 as intangible assets associated with its affiliations as of June 30, 2016 and 2015. There were no impairment charges recorded for the years ended June 30, 2016 and 2015.

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 value 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 or to 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 unrestricted net assets 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 (deficiency) excess of revenue over expenses in the consolidated statements of operation 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 (deficiency) excess of revenue over expenses.

Gifts and Bequests
Unrestricted gifts and bequests 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 market value at the date the gift is received. Gifts are reported as either temporarily or permanently restricted 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, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Reclassifications
Certain amounts in the 2015 consolidated financial statements have been reclassified to conform to the 2016 presentation. In 2016 the presentation of net assets released from restrictions was changed from a single line presentation in the consolidated statement of operations to one in which the net assets released from restriction are classified in their natural expense classifications.

Recently Issued Accounting Pronouncements
In May 2014, the Financial Accounting Standards Board (FASB) issued ASU 2014-09 - Revenue from Contracts with Customers at the conclusion of a joint effort with the International Accounting Standards Board to create common revenue recognition guidance for U.S. GAAP and international accounting standards. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services, by allocating transaction price to identified performance obligations, and recognizing that revenue as performance obligations are satisfied. Qualitative and quantitative disclosures will be required to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The original standard was effective for fiscal years beginning after December 15, 2016; however, in July 2015, the FASB approved a one-year deferral of this standard, with a new effective date for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

In May 2015, the FASB issued ASU 2015-07- Disclosures for Certain Entities That Calculate Net Asset Value per Share (or its Equivalent), which removes the requirement to categorize within the fair value hierarchy all investments for which fair value is measured using net asset value per share as the practical expedient. This guidance is effective in fiscal year 2017. The Health System is evaluating the impact this will have on the consolidated financial statements.

In April 2015, the FASB issued ASU 2015-03 - Imputation of Interest: Simplifying the Presentation of Debt Issuance Costs, which requires all costs incurred to issue debt to be presented in the balance sheet as a direct deduction from the carrying value of the associated debt liability. This guidance is effective for fiscal years beginning after December 15, 2015, or fiscal 2017 for the Health System. The Health System is evaluating the impact this will have on the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02 - Leases, 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, in 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. Early adoption is permitted. 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) may be early adopted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14 - Presentation of Financial Statements for Not-for-Profit Entities, which makes targeted changes to the not-for-profit financial reporting model. The new ASU marks the completion of the first phase of a larger project aimed at improving not-for-profit financial reporting. Under the new ASU, net asset reporting will be streamlined and clarified. The existing three-category classification of net assets will be replaced with a simplified model that combines temporarily restricted and permanently restricted into a single category called "net assets with donor restrictions." The guidance for classifying deficiencies in endowment funds and on accounting for the lapsing of restrictions on gifts to acquire property, plant, and equipment have also been simplified and clarified. New disclosures will highlight restrictions on the use of resources that make otherwise liquid assets unavailable for meeting near-term financial requirements. Not-for-profits will continue to have flexibility to decide whether to report an operating subtotal and if so, to self-define what is included or excluded. However, if the operating subtotal includes internal transfers made by the governing board, transparent disclosure must be provided. The ASU also imposes several new requirements related to reporting expenses, including providing information about expenses by their natural classification. The ASU is effective for fiscal years beginning after December 15, 2017 or fiscal year 2019 for the Health System and early adoption is permitted. The Health System is evaluating the impact of the new guidance on the consolidated financial statements.

3. Acquisitions

Effective March 1, 2016, D-HH became the sole corporate member of APD through an affiliation agreement. APD is a not-for-profit corporation providing inpatient and outpatient services to residents of the Upper Valley in NH and VT. APD has a fiscal year end of September 30.

The D-HH 2016 consolidated financial statements reflect four months of activity for APD beginning March 1, 2016.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, The Health System recorded contribution income of approximately $18,782,000 reflecting the fair value of the contributed net assets of APD, on the transaction date. Of this amount $18,083,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statement of operations. Restricted contribution income of $670,000 and $29,000 was recorded within temporarily and permanently net assets, respectively in the accompanying consolidated statement of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs are expensed as incurred.

The fair value of assets, liabilities, and net assets contributed by APD at March 1, 2016 were as follows:

(in thousands of dollars)

Assets		
Cash and cash equivalents	$	12,619
Patient accounts receivable, net		10,271
Property, plant, and equipment, net		16,600
Other assets		4,939
Estimated third-party settlements		2,397
Total assets acquired	$	46,826
Liabilities		
Accounts payable and accrued expenses	$	6,823
Accrued compensation and related benefits		3,347
Long-term debt		17,181
Other liabilities		693
Total liabilities assumed		28,044
Net Assets		
Unrestricted		18,083
Temporarily restricted		670
Permanently restricted		29
Total net assets		18,782
Total liabilities and net assets	$	46,826

A summary of the financial results of APD included in the consolidated statement of operations and changes in net assets for the period from the date of acquisition March 1, 2016 through June 30, 2016 is as follows:

(in thousands of dollars)

Total operating revenues	$	20,973
Total operating expenses		21,374
Operating gain		(401)
Nonoperating gains		235
Excess of revenue over expenses		(166)
Net assets transferred to affiliate		18,782
Changes in temporarily and permanently net assets		24
Increase in net assets	$	18,640

A summary of the consolidated financial results of the Health System for the years ended June 30, 2016 and 2015 as if the transactions had occurred on July 1, 2014 are as follows (unaudited):

(in thousands of dollars)	2016	2015
Total operating revenues	$ 1,835,177	$ 1,658,250
Total operating expenses	1,872,167	1,671,124
Operating loss	(36,990)	(12,874)
Nonoperating gains	(6,045)	81,277
(Deficiency) excess of revenue over expenses	(43,035)	68,403
Net assets released from restriction used for capital purchases	3,248	2,411
Change in funded status of pension and other post retirement benefits	(66,541)	(65,128)
Change in fair value on interest rate swaps	(5,873)	(931)
(Decrease) increase in unrestricted net assets	$ (112,201)	$ 4,755

4. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debts as follows for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Gross patient service revenue	$ 4,426,305	$ 3,656,514
Less: Contractual allowances	2,737,030	2,258,393
Provision for bad debt	55,121	17,562
Net patient service revenue	$ 1,634,154	$ 1,380,559

Accounts receivable are reduced by an allowance for estimated uncollectibles. In evaluating the collectability of accounts receivable, the Health System analyzes past collection history and identifies trends for several categories of self-pay accounts (uninsured, residual balances, pre-collection accounts and charity) to estimate the appropriate allowance percentages in establishing the allowance for bad debt expense. Management performs collection rate look-back analyses on a quarterly basis to evaluate the sufficiency of the allowance for estimated uncollectibles. Throughout the year, after all reasonable collection efforts have been exhausted, the difference between the standard rates and the amounts actually collected, including contractual adjustments and uninsured discounts, will be written off against the allowance for estimated uncollectibles. In addition to the review of the categories of revenue, management monitors the write offs against established allowances as of a point in time to determine the appropriateness of the underlying assumptions used in estimating the allowance for estimated uncollectibles.

Accounts receivable, prior to adjustment for estimated uncollectibles, are summarized as follows at June 30, 2016 and 2015:

(in thousands of dollars)		2016		2015
Receivables				
Patients	$	126,320	$	123,881
Third-party payors		244,716		171,141
Nonpatient		8,355		1,782
	$	379,391	$	296,804

The allowance for estimated uncollectibles is $118,403,000 and $92,532,000 as of June 30, 2016 and 2015.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2016 and 2015:

	2016	2015
Medicare	42 %	40 %
Anthem/blue cross	19	21
Commercial insurance	22	20
Medicaid	14	15
Self-pay/other	3	4
	100 %	100 %

The Health System has agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the years ended June 30, 2016 and 2015 with major third-party payors follows:

Medicare
The Health System's inpatient acute care services provided to Medicare program beneficiaries are paid at prospectively determined rates-per-discharge. These rates vary according to a patient classification system that is 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. Under the system, outpatient services are reimbursed based on a pre-determined amount for each outpatient procedure, subject to various mandated modifications. The Health System is reimbursed during the year for services to Medicare beneficiaries based on varying interim payment methodologies. Final settlement is determined after the submission of an annual cost report and subsequent audit of this report by the Medicare fiscal intermediary.

Certain of the Health System's affiliates qualify as Critical Access Hospitals (CAH), which are reimbursed by Medicare at 101% (subject to sequestration of 2%) of reasonable costs for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home and the rehabilitation distinct-

part-unit are not impacted by CAH designation. Medicare reimburses both services based on an acuity driven prospective payment system with no retrospective settlement.

Medicaid
The Health System's payments for inpatient services rendered to NH Medicaid beneficiaries are based on a prospective payment system, while outpatient services are reimbursed on a retrospective cost basis or fee schedules. NH Medicaid Outpatient Direct Medical Education costs are reimbursed, as a pass-through, based on the filing of the Medicare cost report. Payment for inpatient and outpatient services rendered to VT Medicaid beneficiaries are based on prospective payment systems and the skilled nursing facility is reimbursed on a prospectively determined per diem rate.

During the years ended June 30, 2016 and 2015, the Health System recorded State of NH Medicaid Enhancement Tax (MET) and State of VT Provider Tax of $58,565,000 and $51,996,000, respectively. The taxes are calculated at 5.5% for NH and 6% for VT of certain net patient 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.

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 "SB 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 Medicaid Enhancement Tax Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the years ended June 30, 2016 and 2015, the Health System received disproportionate share hospital (DSH) payments of approximately $56,718,000 and $10,152,000, respectively which is included in Net Patient Service Revenue in the consolidated statement of operations and changes in net assets.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers and eligible professionals over the next several years with an anticipated end date of December 31, 2016, depending on the program. The Health System has recognized $2,330,000 and $4,175,000 in meaningful use incentives for both the Medicare and VT Medicaid programs during the years ended June 30, 2016 and 2015, respectively.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Compliance with laws and regulations can be subject to future government review and interpretation as well as significant regulatory action; failure to comply with such laws and regulations can result in fines, penalties and exclusion from the Medicare and Medicaid programs.

Other

For services provided to patients with commercial insurance the Health System receives payment for inpatient services at prospectively determined rates-per-discharge, prospectively determined per diem rates or a percentage of established charges. Outpatient services are reimbursed on a fee schedule or at a discount from established charges.

Nonacute and physician services are paid at various rates under different arrangements with governmental payors, commercial insurance carriers and health maintenance organizations. The basis for payments under these arrangements includes prospectively determined per visit rates, discounts from established charges, fee schedules, and reasonable cost subject to limitations.

The Health System has provided for its estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2007 - 2015). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2016 and 2015, changes in prior estimates related to the Health System's settlements with third-party payors resulted in (decreases) increases in net patient service revenue of ($859,000) and $5,550,000 respectively, in the consolidated statements of operations and changes in net assets.

5. Investments

The composition of investments at June 30, 2016 and 2015 is set forth in the following table:

(in thousands of dollars)	2016	2015
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 12,915	$ 8,475
U.S. government securities	33,578	36,634
Domestic corporate debt securities	65,610	80,254
Global debt securities	119,385	111,156
Domestic equities	100,009	106,350
International equities	61,768	69,965
Emerging markets equities	34,282	36,591
Real Estate Investment Trust	432	621
Private equity funds	33,209	26,843
Hedge funds	52,337	56,590
	513,525	533,479
Investments held by captive insurance companies (Note 12)		
U.S. government securities	22,484	27,730
Domestic corporate debt securities	29,123	32,017
Global debt securities	5,655	4,883
Domestic equities	7,830	7,669
International equities	11,901	12,869
	76,993	85,168
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	1,950	1,778
Total assets limited as to use	$ 592,468	$ 620,425

(in thousands of dollars)	2016	2015
Other investments for restricted activities		
Cash and short-term investments	$ 12,219	$ 5,448
U.S. government securities	21,351	19,730
Domestic corporate debt securities	33,203	34,548
Global debt securities	20,808	18,947
Domestic equities	19,215	18,354
International equities	13,986	14,777
Emerging markets equities	4,887	5,077
Real Estate Investment Trust	470	533
Private equity funds	4,780	3,653
Hedge funds	11,087	10,921
Other	30	28
Total other investments for restricted activities	$ 142,036	$ 132,016

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 when debt securities or equity securities 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, 2016 and 2015. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

(in thousands of dollars)		2016	
	Fair Value	Equity	Total
Cash and short-term investments	$ 27,084	$ -	$ 27,084
U.S. government securities	77,413	-	77,413
Domestic corporate debt securities	101,271	26,665	127,936
Global debt securities	40,356	105,492	145,848
Domestic equities	115,082	11,972	127,054
International equities	23,271	64,384	87,655
Emerging markets equities	331	38,838	39,169
Real Estate Investment Trust	20	882	902
Private equity funds	-	37,989	37,989
Hedge funds	-	63,424	63,424
Other	30	-	30
	$ 384,858	$ 349,646	$ 734,504

(in thousands of dollars)		2015	
	Fair Value	Equity	Total
Cash and short-term investments	$ 15,700	$ -	$ 15,700
U.S. government securities	84,095	-	84,095
Domestic corporate debt securities	115,698	31,121	146,819
Global debt securities	54,193	80,792	134,985
Domestic equities	119,883	12,491	132,374
International equities	25,790	71,822	97,612
Emerging markets equities	95	41,571	41,666
Real Estate Investment Trust	-	1,154	1,154
Private equity funds	-	30,496	30,496
Hedge funds	-	67,512	67,512
Other	28	-	28
	$ 415,482	$ 336,959	$ 752,441

Investment income (losses) is comprised of the following for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Unrestricted		
Interest and dividend income, net	$ 5,088	$ 7,927
Net realized gains on sales of securities	(1,223)	12,432
Change in net unrealized gains on investments	(22,980)	(28,824)
	(19,115)	(8,465)
Temporarily restricted		
Interest and dividend income, net	536	1,151
Net realized gains on sales of securities	(18)	646
Change in net unrealized gains on investments	(1,674)	(1,619)
	(1,156)	178
Permanently restricted		
Change in net unrealized losses on beneficial interest in trust	(219)	(187)
	(219)	(187)
	$ (20,490)	$ (8,474)

For the years ended June 30, 2016 and 2015 unrestricted investment income (losses) is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $988,000 and $2,550,000 and as nonoperating (losses) gains of approximately ($20,103,000) and ($11,015,000), 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, 2016 and 2015, the Health System has committed to contribute approximately $116,851,000 and $105,782,000 to such funds, of which the Health System has contributed approximately $80,019,000 and $66,918,000 and has outstanding commitments of $36,832,000 and $38,864,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Land	$ 33,004	$ 29,558
Land improvements	36,899	31,750
Buildings and improvements	801,840	714,689
Equipment	744,443	590,501
Equipment under capital leases	20,823	17,824
	1,637,009	1,384,322
Less: Accumulated depreciation and amortization	1,046,617	818,816
Total depreciable assets, net	590,392	565,506
Construction in progress	22,172	35,849
	$ 612,564	$ 601,355

As of June 30, 2016 construction in progress primarily consists of the construction of the Hospice & Palliative Care building and the renovation of the Borwell building in Lebanon, NH. The estimated cost to complete these projects at June 30, 2016 is $20,300,000 and $580,000, respectively. New London Hospital's construction in progress primarily consists of a building addition at Newport Health Center which is expected to be completed in October 2016 at a cost of $1,200,000.

The construction in progress for the Williamson building reported as of June 30, 2015 was completed during the first quarter of fiscal year 2016 and the major inpatient and outpatient rehabilitation renovations taking place at Mt. Ascutney Hospital reported as construction in progress as of June 30, 2015 were completed during the third quarter of fiscal year 2016.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $81,138,000 and $67,414,000 for 2016 and 2015, 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 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).

Interest Rate Swaps
The fair value of interest rate swaps, are determined using the present value of the fixed and floating legs of the swaps. Each series of cash flows are discounted by observable market interest rate curves and credit risk.

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 management 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, 2016 and 2015:

	2016					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 27,084	$ -	$ -	$ 27,084	Daily	1
U.S. government securities	77,413	-	-	77,413	Daily	1
Domestic corporate debt securities	27,626	73,645	-	101,271	Daily–Monthly	1–15
Global debt securities	23,103	17,253	-	40,356	Daily–Monthly	1–15
Domestic equities	115,082	-	-	115,082	Daily–Monthly	1–10
International equities	23,271	-	-	23,271	Daily–Monthly	1–11
Emerging market equities	331	-	-	331	Daily–Monthly	1–7
Real Estate Investment Trust	20	-	-	20	Daily–Monthly	1–7
Other	-	30	-	30	Not applicable	Not applicable
Total investments	293,930	90,928	-	384,858		
Deferred compensation plan assets						
Cash and short-term investments	2,478	-	-	2,478		
U.S. government securities	30	-	-	30		
Domestic corporate debt securities	6,710	-	-	6,710		
Global debt securities	794	-	-	794		
Domestic equities	23,502	-	-	23,502		
International equities	8,619	-	-	8,619		
Emerging market equities	2,113	-	-	2,113		
Real estate	2,057	-	-	2,057		
Multi strategy fund	9,188	-	-	9,188		
Guaranteed contract	-	-	80	80		
Total deferred compensation plan assets	55,491	-	80	55,571	Not applicable	Not applicable
Beneficial interest in trusts			9,087	9,087	Not applicable	Not applicable
Total assets	$ 349,421	$ 90,928	$ 9,167	$ 449,516		
Liabilities						
Interest rate swaps	$ -	$ 28,917	$ -	$ 28,917	Not applicable	Not applicable
Total liabilities	$ -	$ 28,917	$ -	$ 28,917		

(in thousands of dollars)	2015					
	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	$ 15,700	$ -	$ -	$ 15,700	Daily	1
U.S. government securities	84,095	-	-	84,095	Daily	1
Domestic corporate debt securities	34,671	81,027	-	115,698	Daily–Monthly	1–15
Global debt securities	44,107	10,086	-	54,193	Daily–Monthly	1–15
Domestic equities	119,883	-	-	119,883	Daily–Monthly	1–10
International equities	25,790	-	-	25,790	Daily–Monthly	1–11
Emerging market equities	95	-	-	95	Daily–Monthly	1–7
Other	-	28	-	28	Not applicable	Not applicable
Total investments	324,341	91,141	-	415,482		
Deferred compensation plan assets						
Cash and short-term investments	2,988	-	-	2,988		
U.S. government securities	46	-	-	46		
Domestic corporate debt securities	5,765	-	-	5,765		
Global debt securities	748	-	-	748		
Domestic equities	21,861	-	-	21,861		
International equities	8,808	-	-	8,808		
Emerging market equities	2,232	-	-	2,232		
Real estate	1,874	-	-	1,874		
Multi strategy fund	8,155	-	-	8,155		
Guaranteed contract	-	-	78	78		
Total deferred compensation plan assets	52,477	-	78	52,555	Not applicable	Not applicable
Beneficial interest in trusts	-	-	9,345	9,345	Not applicable	Not applicable
Total assets	$ 376,818	$ 91,141	$ 9,423	$ 477,382		
Liabilities						
Interest rate swaps	$ -	$ 24,740	$ -	$ 24,740	Not applicable	Not applicable
Total liabilities	$ -	$ 24,740	$ -	$ 24,740		

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

(in thousands of dollars)	2016		
	Beneficial Interest in Perpetual Trust	**Guaranteed Contract**	**Total**
Balances at beginning of year	$ 9,345	$ 78	$ 9,423
Purchases			-
Sales			-
Net unrealized gains (losses)	(258)	2	(256)
Net asset transfer from affiliate			-
Balances at end of year	$ 9,087	$ 80	$ 9,167

(in thousands of dollars)	2015			
	Beneficial Interest in Perpetual Trust	Contribution Receivable From Charitable Remainder Trust	Guaranteed Contract	Total
Balances at beginning of year	$ 1,909	$ 2,118	$ 75	$ 4,102
Purchases	-	-	3	3
Sales	-	(2,118)	-	(2,118)
Net unrealized gains (losses)	(198)	-	-	(198)
Net asset transfer from affiliate	7,634	-	-	7,634
Balances at end of year	$ 9,345	$ -	$ 78	$ 9,423

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, 2016 and 2015.

8. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Healthcare services	$ 44,561	$ 43,822
Research	16,680	16,376
Purchase of equipment	2,826	2,483
Charity care	1,543	2,900
Health education	8,518	9,181
Other	1,603	1,695
	$ 75,731	$ 76,457

Permanently restricted net assets consist of the following at June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Healthcare services	$ 32,105	$ 25,015
Research	7,767	7,689
Purchase of equipment	5,266	6,291
Charity care	2,991	5,609
Health education	5,408	8,454
Other	53	23
	$ 53,590	$ 53,081

Income earned on permanently restricted net assets is available for these purposes.

9. Board Designated and Endowment Funds

Net assets include approximately 65 individual 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 Act (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 classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, 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.

Unrestricted net assets 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. Temporarily restricted net assets 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 temporary restrictions on these funds have been met, the funds are reclassified to unrestricted net assets.

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, 2016 and 2015.

Endowment net asset composition by type of fund consists of the following at June 30, 2016 and 2015:

(in thousands of dollars)	2016 Unrestricted	2016 Temporarily Restricted	2016 Permanently Restricted	2016 Total
Donor-restricted endowment funds	$ -	$ 25,780	$ 45,402	$ 71,182
Board-designated endowment funds	26,205	-	-	$ 26,205
Total endowed net assets	$ 26,205	$ 25,780	$ 45,402	$ 97,387

(in thousands of dollars)	2015 Unrestricted	2015 Temporarily Restricted	2015 Permanently Restricted	2015 Total
Donor-restricted endowment funds	$ -	$ 28,296	$ 44,491	$ 72,787
Board-designated endowment funds	26,405	-	-	26,405
Total endowed net assets	$ 26,405	$ 28,296	$ 44,491	$ 99,192

Changes in endowment net assets for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016 Unrestricted	2016 Temporarily Restricted	2016 Permanently Restricted	2016 Total
Balances at beginning of year	$ 26,405	$ 28,296	$ 44,491	$ 99,192
Net investment return	(54)	(1,477)	3	$ (1,528)
Contributions	-	271	699	$ 970
Transfers	-	(216)	180	$ (36)
Release of appropriated funds	(146)	(1,094)	-	$ (1,240)
Net asset transfer from affiliates	-	-	29	$ 29
Balances at end of year	$ 26,205	$ 25,780	45,402	$ 97,387

Balances at end of year	45,402
Beneficial interest in perpetual trust	8,188
Permanently restricted net assets	$ 53,590

	2015			
(in thousands of dollars)	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Balances at beginning of year	$ 19,834	$ 13,738	$ 34,360	$ 67,932
Net investment return	143	(223)	1	(79)
Contributions	-	974	254	1,228
Transfers	-	(370)	158	(212)
Release of appropriated funds	(664)	(2,425)	(46)	(3,135)
Net asset transfer from affiliates	7,092	16,602	9,764	33,458
Balances at end of year	$ 26,405	$ 28,296	44,491	$ 99,192

Balances at end of year	44,491
Beneficial interest in perpetual trust	8,590
Permanently restricted net assets	$ 53,081

10. Long-Term Debt

A summary of long-term debt at June 30, 2016 and 2015 follows:

(in thousands of dollars)	2016	2015
Variable rate issues		
New Hampshire Health and Education Facilities Authority (NHHEFA) Revenue Bonds		
Series 2015A, principal maturing in varying annual amounts, through August 2031 (1)	$ 86,710	$ -
Series 2013, principal maturing in varying annual amounts, through August 2043 (9)*	19,230	17,668
Series 2011, principal maturing in varying annual amounts, through August 2031 (6)	-	90,005
Vermont Educational and Health Buildings Financing Agency (VEHFBA) Revenue Bonds		
Series 2010A, principal maturing in varying annual amounts, through August 2030 (11)*	7,881	8,182
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2014A, principal maturing in varying annual amounts, through August 2022 (3)	26,960	26,960
Series 2014B, principal maturing in varying annual amounts, through August 2033 (3)	14,530	14,530
Series 2012A, principal maturing in varying annual amounts, through August 2031 (4)	72,720	73,725
Series 2012B, principal maturing in varying annual amounts, through August 2031 (4)	39,900	40,455
Series 2012, principal maturing in varying annual amounts, through July 2039 (10)*	27,490	28,818
Series 2010, principal maturing in varying annual amounts, through August 2040 (7)	75,000	75,000
Series 2010, principal maturing in varying annual amounts, through August 2040 (12)	16,287	
Series 2009, principal maturing in varying annual amounts, through August 2038 (8)	63,370	68,970
*Represents nonobligated group bonds		
Other		
Revolving Line of Credit, principal maturing through March 2019 (2)	49,750	-
Series 2012, principal maturing in varying annual amounts, through July 2025 (5)	140,000	144,000
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	313	4
Note payable to a financial institution due in monthly interest only payments from October 2011 through September 2012, and monthly installments from October 2016 through 2016, including principal and interest at 3.25%; collateralized by savings account	2,952	1,915
Note payable to a financial institution payable in interest free entire principal due June 2029 collateralized by land and building	494	555
Obligations under capital leases	4,875	3,369
	648,462	594,156
Less		
Original issue discount, net	881	1,493
Current portion	18,307	17,179
	$ 629,274	$ 575,484

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

(in thousands of dollars)		**2016**
2017	$	18,307
2018		19,117
2019		69,159
2020		20,262
2021		20,290
Thereafter		501,327
	$	648,462

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 MHMH and DHC.

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 of which are the Annual Debt Service Coverage Ratio (1.10x) and the Days Cash on Hand Ratio (> 75 days).

(1) Series 2015A Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds and to cover cost of issuance. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30 2016 was 1.11%

(2) Revolving Line of Credit
Through the DHOG, entered into Revolving Line of Credit TD Bank, N.A. (TD Bank). Interest on the TD Bank loan accrues variably and matures at various dates through March 2019. The variable rate as of June 30 2016 was 1.04%

(3) Series 2014A and Series 2014B Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2014A and Series 2014B in August 2014. The proceeds from the Series 2014A and 2014B 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 2012A and 2012B Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2012A and Series 2012B in November 2012. The proceeds from the Series 2012A and 2012B were used to advance refund the Series 2002 Revenue Bonds and to cover cost of issuance. Interest on the 2012A Revenue Bonds is fixed with an interest rate of 2.29% and matures at various dates through 2031. Interest on the Series 2012B Revenue Bonds is fixed with an interest rate of 2.33% and matures at various dates through 2031.

(5) Series 2012 Bank Loan
Through the DHOG, issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2025.

(6) Series 2011 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2011 in August 2011. The proceeds from the Series 2011 Revenue Bonds were primarily used to advance refund the Series 2001A Revenue Bonds. The Series 2011 Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30 2016 was 1.04%: The Series 2011 Bonds are callable by the bank upon the end of seven years or may be renegotiated at that time. These bonds were paid with the proceeds of the Series 2015A Revenue Bonds.

(7) Series 2010 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2010, in June 2010. The proceeds from the Series 2010 Revenue Bonds were primarily used to construct a 140,000 square foot ambulatory care facility in Nashua, NH as well as various equipment. Interest on the bonds accrue at a fixed rate of 5.00% and mature at various dates through August 2040.

(8) Series 2009 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 3.00% and 6.00% and mature at various dates through August 2038. Outstanding joint and several indebtedness of the DHOG at June 30, 2016 and 2015 approximates $568,940,000 and $533,645,000, respectively.

Non Obligated Group Bonds

(9) Series 2013 Revenue Bonds
Issued through the NHHEFA $15,520;000 tax exempt Revenue Bonds (Series 2013A). The Series 2013A funds were used to refund Series 2007 Revenue Bonds. Additional borrowings were obtained (up to $9,480,000 Revenue Bonds, Series 2013B) for the construction of a new health center building in Newport, NH. The bonds are collateralized by the gross receipts and property. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times the Adjusted LIBOR Rate plus .72 times the credit spread rate. As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with respect to the Series 2007 Revenue Bonds but remains in effect.

(10)Series 2012 Revenue Bonds
Issued through the NHHEFA $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 are collateralized by an interest in its gross receipts under the terms of the bond agreement. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%). Principal is payable in annual installments ranging from $735,000 to $1,750,000 through July 2039.

(11)Series 2010A Revenue Bonds
Issued through the VEHBFA $9,244,000 of Revenue Bonds (Series 2010A). The funds were used to refund 2004 and 2005 Series A Bonds. The bonds are collateralized by gross receipts. The bonds shall bear interest at the one-month LIBOR rate plus 3.50%, multiplied by 6% adjusting monthly. The interest rate at June 30, 2016 was 2.48%. The bonds were purchased by TD Bank on March 1, 2010. Principal payments began on April 1, 2010 for a period of 20 years ranging in amounts from $228,000 in 2014 to $207,000 in 2030.

(12)Series 2010 Revenue Bonds
Issued through the Business Finance Authority (BFA) of the State of NH. 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. APD may prepay certain of these bonds according to the terms of the loan and trust agreement. The bonds are redeemable at any time by APD at par value plus any accrued interest. The bonds are also subject to optional tender for purchase (as a whole) in November 2020 at par plus accrued interest.

The estimated fair value of the Health Systems total long-term debt as of June 30, 2016 and 2015 was approximately $620,217,000 and $606,772,000, respectively, which was determined by discounting the future cash flows of each instrument at rates that reflect rates currently observed in publicly traded debt markets for debt of similar terms to organizations with comparable credit risk. The inputs to the assumptions used to determine the estimated fair value are based on observable inputs and are classified as Level 2. For variable rate debt, the carrying value is equal to the fair value.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $1,950,000 and $1,778,000 at June 30, 2016 and 2015, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets.

For the years ended June 30, 2016 and 2015 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 19,301,000 and $18,442,000 and is included in other nonoperating losses of $3,201,000 and $3,449,000, 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.

A summary of the Health System's derivative financial instruments is as follows:

- A Fixed Payor Swap designed as a cash flow hedge of the NHHEFA Series 2011 Revenue Bonds. The Swap had an initial notional amount of $91,040,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 4.56% in exchange for the counterparty's payment of 67% of USD-LIBOR-BBA. The Swap's term matches that of the associated bonds.

- An Interest Rate Swap to hedge the interest rate risk associated with the NHHEFA Series 2013 Revenue Bonds. The Swap had an initial notional amount of $15,000,000. The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 3.94% in exchange for the counterparty's payment at 67% of USD-LIBOR-BBA. The Swap term matches that of the associated bonds.

- An Interest Rate Swap to hedge the interest rate risk associated with the VEHFBA Series 2010A Revenue Bonds. The Swap had an initial notional amount of $7,244,000.The Swap Agreement requires the Health System to pay the counterparty a fixed rate of 2.41% in exchange for the counterparty's payment of 69% of USD-LIBOR-BBA. The Swap is outstanding until 2017, while the bonds will remain outstanding until 2030.

The obligation of the Health System to make payments on its bonds with respect to interest is in no way conditional upon the Health System's receipt of payments from the interest rate swap agreement counterparty.

At June 30, 2016 and 2015 the fair value of the Health System's interest rate swaps was a liability of $28,917,000 and $24,740,000, respectively. The change in fair value during the years ended June 30, 2016 and 2015 was a decrease of $4,177,000 and $327,000, respectively. For the years ended June 30, 2016 and 2015 the Health System recognized a nonoperating gain of $1,696,000 and 1,035,000 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 affiliates 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 or have been approved by the applicable Board of Trustees to be frozen by December 31, 2017. Effective with that date, the last of the participants earning benefits in any of the Health System's defined benefit plans will no longer earn benefits under the plans.

The Health System continued to execute the settlement of obligations due to retirees in the deferred 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, 2016 and 2015:

(in thousands of dollars)	2016	2015
Service cost for benefits earned during the year	$ 11,084	$ 12,257
Interest cost on projected benefit obligation	48,036	42,276
Expected return on plan assets	(63,479)	(60,458)
Net prior service cost	848	380
Net loss amortization	26,098	21,133
Special/contractural termination benefits	300	56
	$ 22,887	$ 15,644

The following assumptions were used to determine net periodic pension expense as of June 30, 2016 and 2015:

	2016	2015
Weighted average discount rate	4.30 % - 4.90%	4.40 % - 4.90 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded/0.00 % - 2.50 %
Expected long-term rate of return on plan assets	7.50 % - 7.75 %	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, 2016 and 2015:

(in thousands of dollars)	**2016**	**2015**
Change in benefit obligation		
Benefit obligation at beginning of year	$ 988,143	$ 877,082
Additional benefit obligation resulting from new affiliations	-	95,314
Total benefit obligation at beginning of year	988,143	972,396
Service cost	11,084	12,257
Interest cost	48,108	42,276
Benefits paid	(39,001)	(34,803)
Expenses paid	(180)	(139)
Actuarial (gain) loss	99,040	41,079
Settlements	(13,520)	(44,979)
Plan change	2,645	-
Special/contractual termination benefits	300	56
Benefit obligation at end of year	1,096,619	988,143
Change in plan assets		
Fair value of plan assets at beginning of year	845,052	783,890
Additional plan assets at fair value resulting from new affiliations	-	77,608
Total fair value of plan assets at beginning of year	845,052	861,498
Actual return on plan assets	81,210	25,473
Benefits paid	(42,494)	(34,803)
Expenses paid	(180)	(139)
Employer contributions	2,252	38,002
Settlements	(13,520)	(44,979)
Fair value of plan assets at end of year	872,320	845,052
Funded status of the plans	(224,299)	(143,091)
Current portion of liability for pension	(46)	(46)
Long term portion of liability for pension	(224,253)	(143,045)
Liability for pension	$ (224,299)	$ (143,091)

For the years ended June 30, 2016 and 2015 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 unrestricted net assets as of June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Net actuarial loss	$ 423,640	$ 368,959
Prior service cost	228	608
	$ 423,868	$ 369,567

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension expense in 2017 are as follows:

(in thousands of dollars)	
Unrecognized prior service cost	$ 182
Net actuarial loss	30,515
	$ 30,697

The accumulated benefit obligation for the defined benefit pension plans was approximately $1,082,818,000 and $971,193,000 at June 30, 2016 and 2017, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2016 and 2015:

	2016	2015
Weighted average discount rate	4.20 % – 4.30 %	4.90 % - 5.00 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded/0.00 % - 2.50
Expected long-term rate of return on plan assets	7.50 % - 7.75 %	7.50 % - 7.75 %

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 June 30, 2016 and 2015, it is expected that the LDI strategy will hedge approximately 65% and 65%, respectively, 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%	2%
U.S. government securities	0–5	1
Domestic debt securities	20–58	42
Global debt securities	6–26	10
Domestic equities	5–35	18
International equities	5–15	10
Emerging market equities	3–13	5
REIT funds	0–5	0
Private equity funds	0–5	0
Hedge funds	5–18	12

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, 2016 and 2015:

	2016					
(in thousands of dollars)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Redemption or Liquidation**	**Days' Notice**
Investments						
Cash and short-term investments	$ 5,463	$ 10,879	$ -	$ 16,342	Daily	1
U.S. government securities	4,177			4,177	Daily–Monthly	1–15
Domestic debt securities	95,130	296,362		391,492	Daily–Monthly	1–15
Global debt securities	409	88,589		88,998	Daily–Monthly	1–15
Domestic equities	148,998	15,896		164,894	Daily–Monthly	1–10
International equities	12,849	77,299		90,148	Daily–Monthly	1–11
Emerging market equities	352	37,848		38,200	Daily–Monthly	1–17
REIT funds	356	1,465		1,821	Daily–Monthly	1–17
Private equity funds			255	255	See Note 7	See Note 7
Hedge funds		37,005	38,988	75,993	Quarterly–Annual	60–96
Total investments	$ 267,734	$ 565,343	$ 39,243	$ 872,320		

	2015					
(in thousands of dollars)	**Level 1**	**Level 2**	**Level 3**	**Total**	**Redemption or Liquidation**	**Days' Notice**
Investments						
Cash and short-term investments	$ 8,235	$ 32,876	$ -	$ 41,111	Daily	1
U.S. government securities	4,193	-	-	4,193	Daily–Monthly	1–15
Domestic debt securities	85,948	246,352	-	332,300	Daily–Monthly	1–15
Global debt securities	36,532	45,119	-	81,651	Daily–Monthly	1–15
Domestic equities	152,458	16,532	-	168,990	Daily–Monthly	1–10
International equities	15,284	79,659	-	94,943	Daily–Monthly	1–11
Emerging market equities	376	38,237	-	38,613	Daily–Monthly	1–17
REIT funds	-	1,628	-	1,628	Daily–Monthly	1–17
Private equity funds	-	-	437	437	See Note 7	See Note 7
Hedge funds	-	39,110	42,076	81,186	Quarterly–Annual	60–96
Total investments	$ 303,026	$ 499,513	$ 42,513	$ 845,052		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2016 and 2015:

	2016		
(in thousands of dollars)	**Hedge Funds**	**Private Equity Funds**	**Total**
Balances at beginning of year	$ 42,076	$ 437	$ 42,513
Transfers	-	-	-
Purchases	-	-	-
Sales	(468)	(142)	(610)
Net realized (losses) gains	(55)	155	100
Net unrealized gains	(2,565)	(195)	(2,760)
Balances at end of year	$ 38,988	$ 255	$ 39,243

	2015		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 28,466	$ 3,944	$ 32,410
Additions resulting from new affiliations	14,362	-	14,362
Sales	(2,391)	(3,168)	(5,559)
Net realized (losses) gains	(246)	258	12
Net unrealized gains	1,885	(597)	1,288
Balances at end of year	$ 42,076	$ 437	$ 42,513

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2016 and 2015 were approximately $8,808,000 and $5,234,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2016 and 2015.

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, 2016 and 2015.

The weighted average asset allocation for the Health System's Plans at June 30, 2016 and 2015 by asset category is as follows:

	2016	2015
Cash and short-term investments	2 %	5 %
U.S. government securities	1	-
Domestic debt securities	45	39
Global debt securities	10	10
Domestic equities	19	20
International equities	10	11
Emerging market equities	4	5
Hedge funds	9	10
	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 7.75% per annum.

The Health System is expected to contribute approximately $47,000,000 to the Plans in 2017 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 year ending June 30, 2017 and thereafter:

(in thousands of dollars)	**Pension Plans**
2017	$ 42,067
2018	44,485
2019	47,235
2020	50,490
2021	53,778
2022 – 2026	310,773

Defined Contribution Plans

The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, 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 $29,416,000 and $30,204,000 in 2016 and 2015, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

The Health System also has available to employees of certain affiliates various 403(b) and tax-sheltered annuity plans in which they can participate. Plan specifications vary by affiliate and plan. No employer contributions were made to any of these plans in 2016 and 2015, 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, 2016 and 2015:

(in thousands of dollars)	**2016**	**2015**
Service cost	$ 544	$ 527
Interest cost	2,295	2,347
Amortization net prior service income	(5,974)	-
Amortization net loss	610	-
	$ (2,525)	$ 2,874

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, 2016 and 2015:

(in thousands of dollars)	2016	2015
Change in benefit obligation		
Benefit obligation at beginning of year	$ 50,438	$ 51,006
Additional benefit obligation resulting from new affiliations	-	471
	50,438	51,477
Service cost	544	527
Interest cost	2,295	2,347
Benefits paid	(3,277)	(5,236)
Actuarial loss	1,404	1,323
Employer contributions	(34)	-
Benefit obligation at end of year	51,370	50,438
Funded status of the plans	(51,370)	(50,438)
Current portion of liability for postretirement medical and life benefits	(3,130)	(3,203)
Long term portion of liability for postretirement medical and life benefits	(48,240)	(47,235)
Liability for postretirement medical and life benefits	$ (51,370)	$ (50,438)

During the year ended June 30, 2015 the plan amendments were primarily related to the Board's decision to offer retiree health care benefits to certain affiliates post-65 retirees and covered post-65 dependents through a private Medicare exchange beginning in April 2015.

For the years ended June 30, 2016 and 2015 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 unrestricted net assets are as follows:

(in thousands of dollars)	2016	2015
Net prior service income	$ (27,478)	$ (33,452)
Net actuarial loss	11,080	10,260
	$ (16,398)	$ (23,192)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement income in 2016 and 2015 are as follows:

(in thousands of dollars)	2016	2015
Net prior service income	$ (5,974)	$ (5,974)
Net loss	689	610
	$ (5,285)	$ (5,364)

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.10% in 2016 and an assumed healthcare cost trend rate of 7.25%, trending down to 4.75% in 2021 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, 2016 and 2015 by $4,685,000 and $4,479,000 and the net periodic postretirement medical benefit cost for the years then ended by $284,000 and $275,000, 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, 2016 and 2015 by $3,884,000 and $3,790,000 and the net periodic postretirement medical benefit cost for the years then ended by $234,000 and $233,000, respectively.

12. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College and Cheshire 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. 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. D-H 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.

APD, NLH and MAHHC are covered for malpractice claims under a modified claims-made policy purchased through NEAH. While APD, NLH and MAHHC remain in the current insurance program under this policy, the coverage year is based on the date the claim is filed; subject to a medical incident arising after the retroactive date (includes prior acts). The policy provides modified claims-made coverage for former insured providers for claims that relate to the employee's period of employment at APD, NLH or MAHHC and for services that were provided within the scope of the employee's duties. Therefore, when the employee leaves the corporation, tail coverage is not required.

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2016 and 2015 are summarized as follows:

	2016		
(in thousands of dollars)	HAC *(audited)*	RRG *(unaudited)*	Total
Assets	$ 86,101	$ 2,237	$ 88,338
Shareholders' equity	13,620	806	14,426
Net income	-	50	50

	2015		
(in thousands of dollars)	HAC *(audited)*	RRG *(unaudited)*	Total
Assets	$ 100,418	$ 2,289	$ 102,707
Shareholders' equity	13,620	755	14,375
Net income	-	186	186

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 $10,571,000 and $10,215,000 for the years ended June 30, 2016 and 2015, respectively. Minimum future lease payments under noncancelable operating leases at June 30, 2016 were as follows:

(in thousands of dollars)	
2017	$ 8,441
2018	6,210
2019	4,062
2020	2,663
2021	2,009
Thereafter	274
	$ 23,659

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 $85,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire ranging from December 31, 2015 through July 31, 2016. The Health System has outstanding balances under the lines of credits in the amount of $36,550,000 and $1,200,000 at

June 30, 2016 and 2015, respectively. Interest expense was approximately $551,000 and $193,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2016 and 2015:

(in thousands of dollars)	2016	2015
Program services	$ 1,553,377	$ 1,335,316
Management and general	271,409	225,983
Fundraising	5,901	8,037
	$ 1,830,687	$ 1,569,336

15. Subsequent Events

The Health System has assessed the impact of subsequent events through November 26, 2016, 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.

The Visiting Nurse and Hospice for VT and NH (VNH) became an affiliate of D-HH effective July 1, 2016. The affiliation is designed to improve healthcare for the communities served by VNH and D-H by facilitating collaboration, innovation and cost efficiencies between D-H and VNH. The VNH is a non-profit organization that has provided home health and hospice care services in VT and NH since 1907. The agency is dedicated to delivering outstanding home and community based health and hospice services that enrich the lives of the people they serve. The VNH makes home visits to people of all ages and all states of life regardless of the ability to pay.

Effective October 1, 2016, NLH and MAHHC will be provided professional and general liability insurance through the Hamden Assurance Risk Retention Group, Inc. (RRG) under a modified claims made policy. NLH and MAHHC will join RRG along with existing insureds D-H, Cheshire Medical Center and Dartmouth College.

During the year ended June 30, 2016, Dartmouth College restructured a number of activities at the Geisel School of Medicine (Geisel) to address increasing financial constraints, to improve Geisel's education and research programs, and to align resources and support for these activities. These changes included migration of the operations and fiscal responsibility for clinical academic activities from Dartmouth College to D-H, which included responsibility for the employment, finances, and operational support for clinical research programs. D-H agreed to assume responsibility for the clinical practice of psychiatry and employment of approximately 250 staff (which are either part of the psychiatry practice or clinical research) effective July 1, 2016.

Effective July 1, 2016, NLH, MAHHC and Cheshire were admitted to the Dartmouth-Hitchcock Obligated Group. In connection with the admission of these three members, the Dartmouth-Hitchcock Obligated Group assumed new debt in the amount of $28,039,000 from Cheshire. In addition, $24,605,000 of NLH debt was refinanced in combination with new debt in the amount $10,970,000 to fund the new Williamson Building.

Consolidating Supplemental Information

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Assets								
Current assets								
Cash and cash equivalents	$ 607	$ 2,068	$ 16,640	$ 6,699	$ 5,388	$ 9,192	$ -	$ 40,592
Patient accounts receivable, net	-	220,173	17,836	7,377	5,347	10,255	-	260,988
Prepaid expenses and other current assets	7,463	95,738	5,458	3,209	2,022	4,863	(22,933)	95,820
Total current assets	8,070	317,977	39,934	17,285	12,757	24,310	(22,933)	397,400
Assets limited as to use	-	551,724	17,525	10,345	8,260	4,614	-	592,468
Other investments for restricted activities	217	114,719	18,486	2,843	5,742	29	-	142,036
Property, plant, and equipment, net	76	457,570	75,591	43,204	19,659	16,464	-	612,564
Other assets	17,950	68,921	9,794	5,409	3,943	111	(14,929)	91,199
Total assets	$ 26,313	$ 1,510,911	$ 161,330	$ 79,086	$ 50,361	$ 45,528	$ (37,862)	$ 1,835,667
Liabilities and Net Assets								
Current liabilities								
Current portion of long-term debt	$ -	$ 15,638	$ 755	$ 941	$ 486	$ 507	$ -	$ 18,307
Line of credit	-	35,000	-	-	1,550	-	-	36,550
Current portion of liability for pension and other postretirement plan benefits	-	3,176	-	-	-	-	-	3,176
Accounts payable and accrued expenses	9,857	88,557	15,866	6,791	4,589	4,817	(22,933)	107,544
Accrued compensation and related benefits	-	86,997	7,728	2,052	3,128	3,649	-	103,554
Estimated third-party settlements	-	21,434	1,569	5,206	917	1,424	-	30,550
Total current liabilities	9,857	250,802	25,918	14,990	10,650	10,397	(22,933)	299,681
Long-term debt, excluding current portion	-	553,229	27,283	21,148	11,159	16,455	-	629,274
Insurance deposits and related liabilities	-	56,887	-	-	-	-	-	56,887
Interest rate swaps	-	24,148	-	4,646	123	-	-	28,917
Liability for pension and other postretirement plan benefits, excluding current portion	-	246,816	18,662	-	7,015	-	-	272,493
Other liabilities	-	54,218	3,522	1,135	-	36	-	58,911
Total liabilities	9,857	1,186,100	75,385	41,919	28,947	26,888	(22,933)	1,346,163
Commitments and contingencies								
Net assets								
Unrestricted	16,456	234,609	58,978	32,706	14,099	18,264	(14,929)	360,183
Temporarily restricted	-	57,091	16,454	345	1,496	345	-	75,731
Permanently restricted	-	33,111	10,513	4,116	5,819	31	-	53,590
Total net assets	16,456	324,811	85,945	37,167	21,414	18,640	(14,929)	489,504
Total liabilities and net assets	$ 26,313	$ 1,510,911	$ 161,330	$ 79,086	$ 50,361	$ 45,528	$ (37,862)	$ 1,835,667

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2016

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Assets					
Current assets					
Cash and cash equivalents	$ 1,535	$ 176	$ 355	$ -	$ 2,066
Patient accounts receivable, net	220,173	-	-	-	220,173
Prepaid expenses and other current assets	95,158	487	93	-	95,738
Total current assets	316,866	663	448	-	317,977
Assets limited as to use	551,724	-	-	-	551,724
Other investments for restricted activities	91,879	22,840	-	-	114,719
Property, plant, and equipment, net	454,894	1	2,675	-	457,570
Other assets	68,752	4	165	-	68,921
Total assets	$ 1,484,115	$ 23,508	$ 3,288	$ -	$ 1,510,911
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,638	$ -	$ -	$ -	$ 15,638
Line of Credit	35,000	-	-	-	35,000
Current portion of liability for pension and other postretirement plan benefits	3,176	-	-	-	3,176
Accounts payable and accrued expenses	87,373	1,181	3	-	88,557
Accrued compensation and related benefits	86,997	-	-	-	86,997
Estimated third-party settlements	21,434	-	-	-	21,434
Total current liabilities	249,618	1,181	3	-	250,802
Long-term debt, excluding current portion	553,229	-	-	-	553,229
Insurance deposits and related liabilities	56,887	-	-	-	56,887
Interest rate swaps	24,148	-	-	-	24,148
Liability for pension and other postretirement plan benefits, excluding current portion	246,816	-	-	-	246,816
Other liabilities	54,218	-	-	-	54,218
Total liabilities	1,184,916	1,181	3	-	1,186,100
Commitments and contingencies					
Net assets					
Unrestricted	217,033	14,456	3,120	-	234,609
Temporarily restricted	51,173	5,753	165	-	57,091
Permanently restricted	30,993	2,118	-	-	33,111
Total net assets	299,199	22,327	3,285	-	324,811
Total liabilities and net assets	$ 1,484,115	$ 23,508	$ 3,288	$ -	$ 1,510,911

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2015

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Assets							
Current assets							
Cash and cash equivalents	$ 388	$ 9,279	$ 16,525	$ 7,612	$ 5,105	$ -	$ 38,909
Patient accounts receivable, net	-	177,287	14,053	7,388	5,544	-	204,272
Prepaid expenses and other current assets	11,574	102,954	7,921	3,632	2,616	(28,111)	100,586
Total current assets	11,962	289,520	38,499	18,632	13,265	(28,111)	343,767
Assets limited as to use	-	570,057	23,302	13,412	13,654	-	620,425
Other investments for restricted activities	-	113,117	18,899	-	-	-	132,016
Property, plant, and equipment, net	618	461,044	82,793	37,597	19,303	-	601,355
Other assets	4,263	66,837	10,130	5,451	3,903	(2,134)	88,450
Total assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013
Liabilities and Net Assets							
Current liabilities							
Current portion of long-term debt	$ -	$ 15,196	$ 952	$ 661	$ 370	$ -	$ 17,179
Line of credit	-	-	-	-	1,200	-	1,200
Current portion of liability for pension and other postretirement plan benefits	-	3,249	-	-	-	-	3,249
Accounts payable and accrued expenses	15,708	104,697	20,024	3,843	4,059	(28,110)	120,221
Accrued compensation and related benefits	-	85,064	4,936	2,373	2,491	-	94,864
Estimated third-party settlements	-	26,961	-	8,755	2,883	-	36,599
Total current liabilities	15,708	235,167	25,912	13,632	11,003	(28,110)	273,312
Long-term debt, excluding current portion	-	518,799	28,083	18,020	10,582	-	575,484
Insurance deposits and related liabilities	-	62,356	-	-	-	-	62,356
Interest rate swaps	-	20,937	-	3,531	272	-	24,740
Liability for pension and other postretirement plan benefits, excluding current portion	-	175,948	8,374	-	5,958	-	190,280
Other liabilities	-	51,303	3,671	1,135	-	-	56,109
Total liabilities	15,708	1,064,510	66,040	36,318	27,815	(28,110)	1,182,281
Commitments and contingencies							
Net assets							
Unrestricted	1,135	346,900	79,700	34,227	14,367	(2,135)	474,194
Temporarily restricted	-	56,751	17,330	326	2,050	-	76,457
Permanently restricted	-	32,414	10,553	4,221	5,893	-	53,081
Total net assets	1,135	436,065	107,583	38,774	22,310	(2,135)	603,732
Total liabilities and net assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2015

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Assets					
Current assets					
Cash and cash equivalents	$ 8,252	$ 182	$ 845	$ -	$ 9,279
Patient accounts receivable, net	177,287	-	-	-	177,287
Prepaid expenses and other current assets	102,425	338	438	(247)	102,954
Total current assets	287,964	520	1,283	(247)	289,520
Assets limited as to use	570,057	-	-	-	570,057
Other investments for restricted activities	89,176	23,941	-	-	113,117
Property, plant, and equipment, net	458,368	1	2,675	-	461,044
Other assets	66,675	3	159	-	66,837
Total assets	$ 1,472,240	$ 24,465	$ 4,117	$ (247)	$ 1,500,575
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,196	$ -	$ -	$ -	$ 15,196
Current portion of liability for pension and other postretirement plan benefits	3,249	-	-	-	3,249
Accounts payable and accrued expenses	102,666	1,536	742	(247)	104,697
Accrued compensation and related benefits	85,064	-	-	-	85,064
Estimated third-party settlements	26,961	-	-	-	26,961
Total current liabilities	233,136	1,536	742	(247)	235,167
Long-term debt, excluding current portion	518,799	-	-	-	518,799
Insurance deposits and related liabilities	62,356	-	-	-	62,356
Interest rate swaps	20,937	-	-	-	20,937
Liability for pension and other postretirement plan benefits, excluding current portion	175,948	-	-	-	175,948
Other liabilities	51,303	-	-	-	51,303
Total liabilities	1,062,479	1,536	742	(247)	1,064,510
Commitments and contingencies					
Net assets					
Unrestricted	328,168	14,517	3,215	-	346,900
Temporarily restricted	50,297	6,294	160	-	56,751
Permanently restricted	30,296	2,118	-	-	32,414
Total net assets	409,761	22,929	3,375	-	436,065
Total liabilities and net assets	$ 1,472,240	$ 24,465	$ 4,117	$ (247)	$ 1,500,575

Dartmouth-Hitchcock Health and Subsidiaries

Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	Eliminations	Health System Consolidated
Unrestricted revenue and other support								
Net patient service revenue	$ -	$ 1,348,605	$ 161,787	$ 59,789	$ 46,431	$ 20,103	$ (561)	$ 1,634,154
Contracted revenue	1,696	64,286	-	-	-	-	-	65,982
Other operating revenue	3,300	71,475	3,187	3,509	4,555	870	(4,544)	82,352
Net assets released from restrictions	-	8,713	322	65	119	-	-	9,219
Total unrestricted revenue and other support	4,996	1,491,079	165,296	63,363	51,105	20,973	(5,105)	1,791,707
Operating expenses								
Salaries	730	732,393	60,406	29,873	24,019	10,408	14,636	872,465
Employee benefits	219	197,165	19,276	6,824	6,260	2,130	2,533	234,407
Medical supplies and medications	-	236,918	59,121	6,597	4,246	2,932	-	309,814
Purchased services and other	22,506	211,611	14,020	12,876	11,955	4,377	(22,204)	255,141
Medicaid enhancement tax	-	46,078	7,132	2,808	1,707	840	-	58,565
Depreciation and amortization	15	62,348	11,069	4,674	2,345	543	-	80,994
Interest	-	16,821	1,046	823	467	144	-	19,301
Total operating expenses	23,470	1,503,334	172,070	64,475	50,999	21,374	(5,035)	1,830,687
Operating (loss) margin	(18,474)	(12,255)	(6,774)	(1,112)	106	(401)	(70)	(38,980)
Nonoperating gains (losses)								
Investment (losses) gains	(1,027)	(18,848)	(1,075)	627	(15)	235	-	(20,103)
Other, net	(529)	(3,647)	-	57	205	-	69	(3,845)
Contribution revenue from acquisition	18,083	-	-	-	-	-	-	18,083
Total nonoperating gains (losses), net	16,527	(22,495)	(1,075)	684	190	235	69	(5,865)
(Deficiency) excess of revenue over expenses	(1,947)	(34,750)	(7,849)	(428)	296	(166)	(1)	(44,845)
Unrestricted net assets								
Net assets released from restrictions (Note 8)	-	2,185	107	23	586	347	-	3,248
Change in funded status of pension and other postretirement benefits	-	(52,262)	(12,982)	-	(1,297)	-	-	(68,541)
Net assets transferred to (from) affiliates	4,475	(22,558)	-	-	-	18,083	-	-
Additional paid in capital	12,793	-	-	-	-	-	(12,793)	-
Change in fair value on interest rate swaps	-	(4,907)	-	(1,115)	149	-	-	(5,873)
Increase (decrease) in unrestricted net assets	$ 15,321	$ (112,292)	$ (20,724)	$ (1,520)	$ (266)	$ 18,264	$ (12,794)	$ (114,011)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2016

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,346,605	$ -	$ -	$ -	$ 1,346,605
Contracted revenue	63,188	1,578	-	(480)	64,286
Other operating revenue	69,902	1,957	550	(934)	71,475
Net assets released from restrictions	7,928	785	-	-	8,713
Total unrestricted revenue and other support	1,487,623	4,320	550	(1,414)	1,491,079
Operating expenses					
Salaries	731,721	-	-	672	732,393
Employee benefits	197,050	-	-	115	197,165
Medical supplies and medications	236,918	-	-	-	236,918
Purchased services and other	208,763	4,261	646	(2,059)	211,611
Medicaid enhancement tax	46,078	-	-	-	46,078
Depreciation and amortization	62,348	-	-	-	62,348
Interest	16,821	-	-	-	16,821
Total operating expenses	1,499,699	4,261	646	(1,272)	1,503,334
Operating (loss) margin	(12,076)	59	(96)	(142)	(12,255)
Nonoperating gains (losses)					
Investment losses	(18,537)	(311)	-	-	(18,848)
Other, net	(3,789)	-	-	142	(3,647)
Total nonoperating (losses) gains, net	(22,326)	(311)	-	142	(22,495)
Deficiency of revenue over expenses	(34,402)	(252)	(96)	-	(34,750)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	1,994	191	-	-	2,185
Change in funded status of pension and other postretirement benefits	(52,262)	-	-	-	(52,262)
Net assets transferred from affiliates	(22,558)	-	-	-	(22,558)
Change in fair value on interest rate swaps	(4,907)	-	-	-	(4,907)
Decrease in unrestricted net assets	$ (112,135)	$ (61)	$ (96)	$ -	$ (112,292)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2015

(in thousands of dollars)	D-HH (Parent)	D-H and Subsidiaries	NLH and Subsidiaries	Cheshire and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support							
Net patient service revenue	$ -	$ 1,225,872	$ 56,356	$ 52,536	$ 46,102	$ (307)	$ 1,380,559
Contracted revenue	-	82,091	-	-	-	(1,256)	80,835
Other operating revenue	12,203	69,663	3,063	1,076	3,526	(6,538)	82,993
Net assets released from restrictions	-	15,314	111	212	-	-	15,637
Total unrestricted revenue and other support	12,203	1,392,940	59,530	53,824	49,628	(8,101)	1,560,024
Operating expenses							
Salaries	960	696,358	27,562	20,949	24,076	8,482	778,387
Employee benefits	263	195,271	5,764	5,724	6,112	1,493	214,627
Medical supplies and medications	139	201,451	5,910	8,712	3,736	19	219,967
Purchased services and other	17,448	180,706	13,317	13,747	11,888	(18,402)	218,704
Medicaid enhancement tax	-	45,839	1,941	2,363	1,853	-	51,996
Depreciation and amortization	75	56,649	4,075	3,436	2,978	-	67,213
Interest	-	16,781	849	357	455	-	18,442
Total operating expenses	18,885	1,393,055	59,418	55,288	51,098	(8,408)	1,569,336
Operating (loss) margin	(6,682)	(115)	112	(1,464)	(1,470)	307	(9,312)
Nonoperating gains (losses)							
Investment (losses) gains	-	(12,011)	625	311	60	-	(11,015)
Other, net	339	(2,880)	1,409	141	57	(307)	(1,241)
Contribution revenue from acquisition	92,499	-	-	-	-	-	92,499
Total nonoperating gains (losses), net	92,838	(14,891)	2,034	452	117	(307)	80,243
Excess (deficiency) of revenue over expenses	86,156	(15,006)	2,146	(1,012)	(1,353)	-	70,931
Unrestricted net assets							
Net assets released from restrictions (Note 8)	-	717	5	1,010	679	-	2,411
Change in funded status of pension and other postretirement benefits	-	(62,977)	-	2,875	(790)	-	(60,892)
Net assets transferred (from) to affiliates	(84,626)	(7,873)	-	76,827	15,672	-	-
Additional paid in capital	600	-	-	-	-	(600)	-
Change in fair value on interest rate swaps	-	(869)	(221)	-	159	-	(931)
Increase (decrease) in unrestricted net assets	$ 2,130	$ (86,008)	$ 1,930	$ 79,700	$ 14,367	$ (600)	$ 11,519

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2015

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,225,874	$ -	$ -	$ (2)	$ 1,225,872
Contracted revenue	81,474	847	-	(230)	82,091
Other operating revenue	64,928	2,356	6,482	(4,103)	69,663
Net assets released from restrictions	14,610	704	-	-	15,314
Total unrestricted revenue and other support	1,386,886	3,907	6,482	(4,335)	1,392,940
Operating expenses					
Salaries	695,392	-	-	966	696,358
Employee benefits	195,119	-	-	152	195,271
Medical supplies and medications	201,458	-	-	(7)	201,451
Purchased services and other	172,061	4,079	6,484	(1,918)	180,706
Medicaid enhancement tax	45,839	-	-	-	45,839
Depreciation and amortization	56,649	-	-	-	56,649
Interest	16,781	-	-	-	16,781
Total operating expenses	1,383,299	4,079	6,484	(807)	1,393,055
Operating margin (loss)	3,587	(172)	(2)	(3,528)	(115)
Nonoperating gains (losses)					
Investment (losses) gains	(12,079)	68	-	-	(12,011)
Other, net	(6,408)	-	-	3,528	(2,880)
Total nonoperating (losses) gains, net	(18,487)	68	-	3,528	(14,891)
Deficiency of revenue over expenses	(14,900)	(104)	(2)	-	(15,006)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	454	263	-	-	717
Change in funded status of pension and other postretirement benefits	(62,977)	-	-	-	(62,977)
Net assets transferred from affiliates	(7,873)	-	-	-	(7,873)
Change in fair value on interest rate swaps	(869)	-	-	-	(869)
(Decrease) increase in unrestricted net assets	$ (86,165)	$ 159	$ (2)	$ -	$ (86,008)

1. Basis of Presentation

The accompanying supplemental consolidating information includes the consolidating balance sheet and the consolidating statement of operations and changes in unrestricted net assets of D-HH and subsidiaries. All intercompany accounts and transactions between the D-HH and 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.

Board of Trustees

The Dartmouth-Hitchcock (D-H) Board of Trustees is a dedicated group of individuals who work diligently to ensure that Dartmouth-Hitchcock is well positioned to advance health and to achieve the healthiest population possible in our region and beyond.

The Dartmouth-Hitchcock Board of Trustees consists of public trustees, Dartmouth-Hitchcock Clinic physician trustees, a physician from the D-H Community Group Practices, and the following Ex-officio trustee members: the President of Dartmouth-Hitchcock, and the Dean of the Geisel School of Medicine at Dartmouth.

The Trustees volunteer their time to serve for a three-year term and may be elected for a maximum of three consecutive terms – nine (9) total years. The Trustees are a diverse group of volunteers with backgrounds in business, medicine, law, education, finance, etc. While a majority of Trustees reside in our Vermont/New Hampshire service area, D-H is enriched by having members from throughout the country.

Trustee biographies:

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Feedback

CURRICULUM VITAE

Name: Alan Ivan Green, M.D.

Office Address: Department of Psychiatry, Geisel School of Medicine at Dartmouth
Dartmouth Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756

Email: alan.i.green@dartmouth.edu

Education:

1965	A.B., Columbia College
1969	M.D., The Johns Hopkins University School of Medicine

Postdoctoral Training

Internship and Residencies

1969-1970	Intern in Medicine, Beth Israel Hospital, Boston
1972-1973	Junior Resident in Psychiatry, Boston City Hospital, Boston
1973-1975	Resident in Psychiatry, Massachusetts Mental Health Center, Boston
1975-1981	On medical leave due to systemic cytomegalovirus infection
1981-1982	Resident in Psychiatry, Massachusetts Mental Health Center, Boston

Research Fellowships

1970-1971	Staff Associate, National Institute of Mental Health, Laboratory of Pre-Clinical Pharmacology, Washington, D.C.
1971-1972	On assignment from NIMH to Special Action Office for Drug Abuse Prevention, Executive Office of the President
1982-1984	Clinical Research Training Fellow, Massachusetts Mental Health Center, Boston

Licensure and Certification

1974-2012	California, Board of Medical Quality Assurance
1975	Massachusetts, Board of Registration in Medicine, # 38430
1984	Certification by American Board of Psychiatry and Neurology, #26343
2003	New Hampshire, Board of Medicine, #11912

Faculty Academic Appointments

1969-1970	Clinical Fellow in Medicine, Harvard Medical School
1972-1982	Clinical Fellow in Psychiatry, Harvard Medical School
1982-1984	Senior Research Fellow in Psychiatry, Harvard Medical School
1984	Lecturer in Psychiatry, Harvard Medical School
1984-1994	Assistant Professor of Psychiatry, Harvard Medical School
1994- 2002	Associate Professor of Psychiatry, Harvard Medical School
2002-	Lecturer in Psychiatry, Harvard Medical School
2002-	Raymond Sobel Professor of Psychiatry, Geisel School of Medicine at Dartmouth
2002-	Chairman, Department of Psychiatry, Geisel School of Medicine at Dartmouth
2005-2016	Professor of Pharmacology and Toxicology, Geisel School of Medicine at Dartmouth
2010-	Associate Dean for Clinical and Translational Science, Geisel School of Medicine at Dartmouth
2010-	Director, SYNERGY: The Dartmouth Clinical and Translational Science Institute
2016-	Professor of Molecular and Systems Biology, Geisel School of Medicine at Dartmouth

Hospital Appointments

1981-1984	Assistant Clinical Director, Southard Clinic, Massachusetts Mental Health Center
1982-2008	Staff Psychiatrist, Massachusetts Mental Health Center
1983-2004	Medical Staff, New England Deaconess Hospital
1984-1993	Associate Director of Psychopharmacology, Massachusetts Mental Health Center
1983-1993	Program Director, Psychopharmacology Extramural Training Program, Massachusetts Mental Health Center
1984-2001	Attending Physician, Brockton VA Medical Center
1987-1999	Administrative Director to Director, Commonwealth Research Center, Massachusetts Mental Health Center
1993-2002	Medical Staff, Brigham & Women's Hospital
1999-2002	Director, Commonwealth Research Center, Massachusetts Mental Health Center, Harvard Medical School
1996-2002	Director, Office of Research Administration, Massachusetts Mental Health Center
1998-2002	Director, Neuropsychopharmacology Laboratory, Massachusetts Mental Health Center
2002-	Mary Hitchcock Memorial Hospital, Lebanon, NH
2004-	Consulting Staff, Beth Israel Deaconess Medical Center, Boston, MA
2002-	Chairman, Department of Psychiatry, Dartmouth-Hitchcock Medical Center

Other Professional Positions and Major Visiting Appointments

1971	Special Assistant to Director, Special Action Office for Drug Abuse Prevention, Executive Office of the President, Washington, D.C.
1971-1972	Acting Director of Research, Special Action Office for Drug Abuse Prevention, Executive Office of the President
1972-1973	Director of Biomedical Research, Special Action Office for Drug Abuse Prevention, Executive Office of the President
1973-1975	Consultant, Special Action Office for Drug Abuse Prevention, Executive Office of the President
2001-2002	Vice-President, Massachusetts Mental Health Institute
2001-2005	Member, Board of Directors, Massachusetts Mental Health Institute
2002-	Member, Board of Directors, West Central Behavioral Health
2002-	Member, Board of Governors, Dartmouth Hitchcock Medical Center
2002-	Director, Psychopharmacology Research Group, Department of Psychiatry, Geisel School of Medicine at Dartmouth

Major Administrative Leadership Appointments

1999-2002	Director, Commonwealth Research Center, Harvard Medical School Department of Psychiatry
2002-	Chairman, Department of Psychiatry, Geisel School of Medicine at Dartmouth
2010-	Director, SYNERGY: The Dartmouth Clinical and Translational Science Institute, Dartmouth College

Committee Service

1983-1984	Vice President, Clinical Staff Organization, Massachusetts Mental Health Center
1984	President, Clinical Staff Organization, Massachusetts Mental Health Center
1984-1985	Chairman, Task Force on Neuroleptic Agents, MA Department of Mental Health
1989-1991	Member, Clozapine Task Force, MA Department of Mental Health
1989-1990	Member, Committee on AIDS and Drugs, Harvard AIDS Institute
1991-2002	Member, Research Committee, Dept of Psychiatry, Harvard Medical School
1991-2002	Member, Research Committee, Massachusetts Mental Health Center
1993-1999	Member, MA Department of Mental Health, Research Advisory Committee
1995-1996	Member, Task Force on Informed Consent, MA Department of Mental Health
1998-2002	Member, Promotions Committee, Massachusetts Mental Health Center
2001-2005	Member, Board of Directors, Massachusetts Mental Health Institute
2002-	Advisory Board, Neuroscience Center, Geisel School of Medicine at Dartmouth
2002-2016	Member, Board of Governors, Dartmouth Hitchcock Medical Center
2002-	Member, Board of Directors, West Central Behavioral Health, Lebanon, NH
2013-	Member, National CTSA Steering Committee, NCATS, NIH

Professional Societies

1975-	Member, American Psychiatric Association
1982-	General Member, Massachusetts Psychiatric Society
1983-	Program Committee, Massachusetts Psychiatric Society
1983-1986	Newsletter Editor, Massachusetts Psychiatric Society
1996-	Member, Massachusetts Medical Society
1998-	Member, American Association for the Advancement of Science
1999-2003	Fellow, American Psychiatric Association
2001-	Member, American College of Neuropsychopharmacology
2003-	Distinguished Fellow, American Psychiatric Association
2007-	Distinguished Life Fellow of the American Psychiatric Association
2009-	Member, Collegium Internationale Neuro-Psychopharmacologicum
2011-	Fellow, American College of Neuropsychopharmacology
2012-	Member, Committee on Dual Disorders, World Psychiatric Association

Grant Review Activities

2002	Member, ZMHI/NRB w -13R Study Section (NIMH)
2002	Chairman, ZAAI BB22 Study Section (NIAAA)
2004	Member, Peer Review of RFA-DA-04-016 (NIDA)
2006	Member, Peer Review Panel of RFA DA06-002 (Pilot Clinical Trials) (NIDA)
2009	Member, NIDA "L" Review Committee
2010	Member, ZMH1 ERB-F (08) S Study Section (NIMH)
2010	Member, ZMH1 ERB-F (02) S Study Section (NIMH)
2011	Member, ZRG1 BDCN-C (02) M Study Section (NIH)
2014	Member, ZAA1 DD 10 1, NIAAA Concept Review - Human Lab Paradigms

Editorial Activities

1995-2013	Member, Editorial Board, Harvard Mental Health Letter
2003-	Member, Editorial Board, Schizophrenia Research
2003-	Member, Editorial Board, The Journal of Dual Diagnosis
2008-	Associate Editor, The Journal of Dual Diagnosis

2008-2010	Member, Physician Editorial Board, Neuropsychiatry Reviews
2009-	Assistant Editor, Addiction
2010-2013	Member, Editorial Board, Schizophrenia Bulletin
2010-	Co-Editor, The Journal of Dual Diagnosis

Honors and Prizes

1982	Ethel Dupont-Warren Award, Department of Psychiatry, Harvard Medical School
1988	William F. Milton Fund Award, Harvard Medical School
1990	Outstanding Teacher Award, Brockton VA Medical Center, Dept. of Psychiatry
1997	Best Doctors in Boston: Boston Magazine
1998	Outstanding Psychiatrist Award for Research, Massachusetts Psychiatric Society
1998	NARSAD Independent Investigator Award
1998	Best Doctors in America
1999-	Who's Who in America
2000	Peter Curran Lecturer, Mater Hospital Trust, Belfast, N. Ireland
2003	Distinguished Fellow, American Psychiatric Association
2004	Master of Arts (Hon.), Dartmouth College
2005	Best Doctors in America
2006	Turner Lecturer, Dartmouth Medical School
2007	Joseph J. Schildkraut Memorial Lecturer, University of Massachusetts
2007-	Distinguished Life Fellow of the American Psychiatric Association
2007-	Best Doctors in America
2011-	Fellow, American College of Neuropsychopharmacology
2013	Member of Honour, Spanish Society of Dual Pathology

Major Research Interests

1. Schizophrenia and comorbid substance use disorder: neuropharmacology, neuroimaging and treatment development
2. Medication development for addiction
3. Brain reward circuitry
4. Animal models
5. Early intervention in schizophrenia

Research Funding

Current Federal Grants

2017-2019 NIDA R21DA044501 PI: Green	Reward circuit dysfunction, substance use disorder, and schizophrenia: a preclinical fMRI-based connectivity study
2013-2020 NIDA R01DA034699 PI: Green	Cannabis, schizophrenia and reward: self-medication and agonist treatment?
2013-2019 NCATS 1 UL1 TR001086-03 NCATS 1KL2TR001088-03 PI: Green	Dartmouth SYNERGY| The Dartmouth Clinical and Translational Science Institute
2015-2020 NIH/NIDA 1UH2DA041713 PI: Marsch/Poldrack	Applying Novel Technologies and Methods to Inform the Ontology of Self-Regulation

Current Clinical Trials: None

Current Investigator Initiated Grants from Industry: None

Past NARSAD Grant:

1998-2002 NARSAD Independent Investigator Award PI: Green	Toward the prevention of schizophrenia: treatment of negative symptoms and neurocognitive deficits in first degree relatives

Past Federal Grants

1993-2001 NIMH RO1MH49891 PI: Green	Clozapine response and biogenic amines in schizophrenia
1994-1999 NIMH RO1MH52376 PI: Green	Clozapine vs. haloperidol in first episode schizophrenia
1995-2001 NIMH RO1MH49891-Supp. PI: Green	Clozapine vs. olanzapine: an effectiveness study. Clinical Services Supplement to Grant #RO1MH49891
1995-1998 NIMH RO1MH49891-Supp. PI: Green	Minority Supplement to Grant #RO1MH49891
1999-2004 NIAAA RO1AA11904 PI: Green	Alcoholism and schizophrenia: Effects of clozapine
1999-2004 NIAAA RO1AA11904 PI: Green	Minority Supplement to NIAAA Grant #RO1AA11904
2004-2007 NIAAA R03AA014644 PI: Green	Antipsychotics and alcohol drinking in rodents
2000-2008 NIDA R01DA 13196 PI: Green	Cannabis and schizophrenia: Effects of clozapine
2001-2009 NIMH R21MH62157 PI: Green	Clozapine, cannabis and first episode schizophrenia
2004-2009 NIDA R21DA019215-01 PI: Green	Cannabis and schizophrenia: fMRI Reward Circuit Biomarker
2007-2009 NIAAA CSP-1027	Efficacy of quetiapine fumarate sustained release for the treatment of alcohol dependency

PI: Green	in very heavy drinkers
2007-2010 NIMH 5R03MH075833-02 PI: Chau; Co-PI: Green	Toward a Rat Model of Alcohol Abuse in Schizophrenia
2009-2011 NIAAA/Fast Track NCIG-002 PI: Green	Efficacy of Levetiracetam Extended Release for the treatment of alcohol dependency in very heavy drinkers
2009-2011 NIAAA R13AA018603 PI: Green	Conference: Integrating Etiologic Models and Optimizing Treatment for Alcohol Disorders in Schizophrenia Patients
2010-2012 NIDA R21 DA029131 PI: Sevy	Improving Substance Use and Clinical Outcomes in Heavy Cannabis Users
2011-2012 NIAAA/Fast Track NCIG-003 PI: Green	A Phase 2, Double-Blind, Placebo Controlled Trial to Assess the Efficacy of Varenicline Tartrate for Alcohol Dependence in Very Heavy Drinkers.
2009-2012 NIDA R01DA026799 PI: Green	Cannabis and Schizophrenia: Self-Medication and Agonist Treatment? (No Cost Extension)
2010-2013 NIAAA R01AA018151 PI: Green	Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia (No Cost Extension)
2011-2014 NIAAA R21AA019534 PI: Green	Alcoholism and Schizophrenia: A Translational Approach to Treatment (No Cost Extension)
2014-2015 NCATS 3UL1TR001086-02S1 PI: Green	Enhancing Clinical Research Professionals' Training and Qualifications
2014-2015 NCATS 3UL1TR001086-02S2 PI: Green	Development of a Cross-CTSA IRB Reliance Program (National IRB Reliance Initiative)
2015- 2017 NIAAA/Fast-Track Drugs & Biologics PI: Green	Randomized, Double Blind, Placebo-Controlled Trial of the Safety and Efficacy of HORIZANT® (Gabapentin Enacarbil) Extended-Release Tablets for the Treatment of Alcohol Use Disorder
2012-2017 NIDA R01DA032533 PI: Green	Clozapine for cannabis use disorder in schizophrenia
2015-2018 NCATS 3UL1TR001102-04S1 PI: Nadler	Harvard Clinical and Translational Science Center (Supplement): SMART IRB

Past Investigator Initiated Grants

1989-1990 Milton Fund Harvard Medical School PI: Green	Subgroups of psychotic patients: pharmacologic, biochemical and clinical differences
1991-1994 Sandoz Research Institute PI: Green	Clozapine in psychotic patients
1993-1994 Eli Lilly & Co. PI: Green	Biochemical predictors and correlates of response to olanzapine
1994-1996 Otsuka America Pharm., Inc. PI: Green	Biochemical predictors and correlates of response to OPC-14597
1997-1999 Eli Lilly & Co. PI: Green	Olanzapine vs. typical neuroleptics: prolactin level and ovarian function
1997-1999 Novartis Pharmaceuticals PI: Green	Clozapine's effect on prolactin level and ovarian function
1997-2000 Janssen Research Foundation PI: Green (with MT Tsuang)	Risperidone in relatives of patients with schizophrenia
1997-2001 Eli Lilly & Co. PI: Green	Olanzapine vs. haloperidol in first episode schizophrenia: an addendum study
1999-1999 Novartis Pharmaceuticals PI: Green	Clozapine in patients with schizophrenia and substance abuse
1999-2003 Eli Lilly & Co. PI: Green	Clozapine vs. olanzapine: an effectiveness study
2000-2001 Eli Lilly & Co. PI: Green	Preventing weight gain from novel antipsychotics (feasibility study)
2001-2002 Novartis Pharmaceuticals PI: Green	Does clozapine limit alcohol drinking in Syrian Golden Hamsters?
2002-2006 AstraZeneca PI: Green	Comparison of atypical antipsychotics in first episode schizophrenia

2004-2006 Bristol-Myers Squibb/Otsuka PI: Green	Aripiprazole in alcohol drinking rodents
2000-2007 AstraZeneca PI: Green	Quetiapine in schizophrenia and comorbid substance use disorder (retrospective)
2000-2007 Eli Lilly & Co. PI: Green	Olanzapine in patients with comorbid substance use disorder and schizophrenia (retrospective)
2003-2008 AstraZeneca PI: Green	Efficacy of quetiapine in treating patients with active substance use disorder and schizophrenia
2006-2008 Cyberonics Inc. PI: Green	Does vagus nerve stimulation limit alcohol drinking in the alcohol-preferring Syrian golden hamster?
2004-2008 Janssen Research Foundation PI: Green	Risperidone and alcohol drinking in the Syrian golden hamster and in the alcohol-preferring "P" rat.
2004-2010 Janssen Research Foundation PI: Green	Risperidone long-acting for alcohol and schizophrenia treatment (R-LAST).
2007-2011 Janssen Research Foundation PI: Green	Paliperidone in alcohol drinking rodents
2013-2014 Novartis PI: Green	Iloperidone for alcohol use disorder in schizophrenia
2015-2016 Alkermes PI: Green	Olanzapine-Samidorphan in Alcohol-Preferring Rodents

Past Clinical Trials

1989-1991 Janssen Research Foundation PI: Green	Risperidone in the treatment of schizophrenia
1989-1990 Sandoz Research Institute PI: Green	SDZ HDC-912 in the treatment of schizophrenia
1991-1994 Merck, Sharp & Dome PI: Green	Remoxipride vs. haloperidol in schizophrenic outpatients

1993-1997 Eli Lilly & Co. PI: Green	Fixed-dose olanzapine vs. placebo in the treatment of schizophrenia
1994-1996 Otsuka America Pharm., Inc. PI: Green	OPC-14597 vs. haloperidol and placebo in the treatments of schizophrenia
1994-1996 Pfizer, Inc. PI: Green	Inpatient study of ziprasidone and haloperidol in the acute exacerbation of schizophrenia and schizoaffective disorder
1994-1996 Pfizer, Inc. PI: Green	Evaluating the safety and efficacy of two dose regimens of oral ziprasidone and haloperidol in the maintenance treatment of outpatients with schizophrenia or schizoaffective disorder
1994-2000 Pfizer, Inc. PI: Green	Evaluating the safety and outcome of oral ziprasidone in subjects who have participated in previous clinical trials of ziprasidone
1995-1996 Otsuka America Pharm., Inc. PI: Green	A dose ranging study of OPC-14597 in patients with schizophrenia
1995-2002 Otsuka America Pharm., Inc. PI: Green	An open-label tolerability study of OPC 14597 in schizophrenic patients
1996-1997 Zeneca Pharmaceuticals PI: Green	Health outcomes study of Seroquel and usual care in schizophrenia and schizoaffective disorder
1996-1998 Janssen Research Foundation PI: Green	A comparison of risperidone and haloperidol for prevention of relapse in subjects with schizophrenia and schizoaffective disorders
1997 ICON Clinical Research, Inc. PI: Green	A phase III randomized study comparing 2 doses of intramuscular ziprasidone (2 mg and 20 mg) in subjects with psychosis and acute agitation
1997-1998 Hoescht Marion Rousel, Inc. PI: Green	A multicenter, randomized, double-blind, placebo and active controlled study of MDL 100,907 in schizophrenic and schizoaffective patients
1997-1999 Hoescht Marion Rousel, Inc. PI: Green	A multicenter, open-label, long-term follow-up, safety study of MDL 100,907 in schizophrenic and schizoaffective patients
1997-1999 Otsuka America Pharm., Inc. PI: Green	A study of aripiprazole in schizophrenia

1997-2001 Eli Lilly & Co. PI: Green	The acute and long-term efficacy of olanzapine in first-episode psychotic disorders
1998-2001 Novartis Pharmaceuticals PI: Green	Clozapine vs. olanzapine in patients with schizophrenia and suicidality
2000-2002 Bristol-Myers Squibb PI: Green	A multicenter study of aripiprazole in the treatment of patients with acute schizophrenia
2000-2002 Novartis Pharmaceuticals PI: Green	A multicenter trial of iloperidone in patients with schizophrenia
2003-2005 Eli Lilly & Co. PI: Green	Atomoxetine plus olanzapine for cognitive dysfunction in schizophrenia
2004-2006 Forest Laboratories PI: Green	Memantine in psychosis
2008-2010 H. Lundbeck A/S PI: Green	Neurocognitive effect of sertindole versus quetiapine in patients with schizophrenia.
2008-2010 Eli Lilly and Co. PI: Green	A phase 2 study of LY2196044 compared with naltrexone and placebo in the treatment of alcohol dependence.

Teaching

1. Medical School Courses

1981-1985	Psychiatry 700a, Harvard Medical School
1982-1985	William James Seminar, Harvard Medical School
1983-1986	William James Seminar II, Harvard Medical School
1984-1985	Pathophysiology 905.0, Harvard Medical School
1984-1986	Psychiatry 700b, Harvard Medical School
1986-1989	Psychiatry 700, Harvard Medical School
1989-1997	Psychiatry 700mj, Harvard Medical School
2003-	Medical Neuropharmacology: Antipsychotics, Geisel School of Medicine at Dartmouth
2004-2009	Psych 606: Adolescent Alcohol Abuse, Dartmouth College
2005-	Neurobiology of Psychosis, Geisel School of Medicine at Dartmouth
2006	Pharmacology 131: Neuropharmacology and Imaging Biomarkers, Geisel School of Medicine at Dartmouth
2006-	Schizophrenia and Substance Abuse, Neuroscience Center, Geisel School of Medicine at Dartmouth
2007-	PEMM 131: Neuropharmacology and Imaging Biomarkers, Geisel School of Medicine at Dartmouth
2007-	PEMM 102: Neurotransmitter Transporters, Geisel School of Medicine at Dartmouth
2008-	PEMM 211: Neurobiology of Schizophrenia, Geisel School of Medicine at Dartmouth

2. Hospital Courses and Teaching Presentations

1982-	Psychopharmacology Lecture Series (Annual), Massachusetts Mental Health Center
1982-2002	Board Review Course (CME), Massachusetts Mental Health Center
1983-1993	Psychopharmacology Extramural Training Program (CME), Massachusetts Mental Health Center
1984	Lecturer: Psychoneuroendocrinology, Brockton VA Medical Center
1985-1986	Topics in Psychopharmacology (CME), Lenox, MA
1986-1991	Psychopharmacology Update (CME), Aruba
1986-1994	Psychopharmacology Case Conference and Seminar, Brockton VA Medical Center
1987-1988	Psychopharmacology Update (CME), Massachusetts Department of Mental Health
1989-1994	Psychosis Seminar, Massachusetts Mental Health Center
1989-1992	Affective Disorders Seminar, Massachusetts Mental Health Center
1990-1993	Anxiety Disorders Seminars, Massachusetts Mental Health Center
1991-	Harvard Medical School CME, Essential Psychopharmacology
1993-1994	Harvard Medical School CME, Psychopharmacology for the Family Physician
1993	Brockton VA Medical Center, Typical and Atypical Neuroleptic Drugs
1994	Harvard Longwood Psychiatry Residency, Pharmacological Approach to Schizophrenia
1994	MMHC CME, Psychopharmacology for the internist
1994-2002	Anxiety Disorders Courses, Harvard Longwood Psychiatry Residency
1996-2002	Psychosis Seminar, Harvard Longwood Psychiatry Residency
1997-	Course Director, Essential Psychopharmacology, Harvard CME
2000-2002	Harvard Longwood Psychiatry Residency: lectures on psychopharmacology of psychosis
2003-	Research Seminar, Dartmouth Psychiatry Residency Program
2003-	Psychopharmacology, Pharmacology Course, Year Two, Geisel School of Medicine at Dartmouth
2003-	Psychiatry Grand Rounds, Dartmouth Hitchcock Medical Center
2003	Lecturer, Neuroscience Center at Dartmouth
2003	Psychiatry Grand Rounds, New Hampshire Hospital
2004	Lecturer, Addiction Symposium, Dartmouth Center on Addiction, Recovery and Education
2005	Psychiatry Grand Rounds, New Hampshire Hospital
2005	Pharmacology and Toxicology Seminar Series, Dartmouth Medical School: "Brain Reward Circuit Dysfunction in Schizophrenia: A Target for Therapeutic Intervention?"
2006	Pharmacology 131 Spring Lecture, Dartmouth Medical School. Modern Approaches in Experimental Therapeutics: Neuropharmacology/Brain Imaging
2006	Neuroscience Center at Dartmouth, Pathophysiological Basis of Brain Disease Course: "Neurobiology of Schizophrenia."
2007-	Neuroscience Center at Dartmouth, Pathophysiological Basis of Brain Disease Course: "Neurobiology of Schizophrenia and Substance Abuse.
2011	Dartmouth Community Medical School "Alcohol and Drug Abuse: Is it all about reward?"
2017	Department of Medicine, Dartmouth Hitchcock Medical Center, Grand Rounds "Synergy"

3. Invited Presentations

1972	How Basic Science Might Solve Social Problems in Substance Abuse, Society of Neurosciences, Houston, Texas
1986	New Research in Affective Disorders, Psychiatry Grand Rounds,

	University of Massachusetts
1989	Psychopharmacologic Probes in Psychotic Disorders, Psychiatry Grand Rounds, Dartmouth Medical School
1989	New Treatments for Psychosis, Grand Rounds, Fuller Memorial Hospital
1989	Psychopharmacology in the Substance Abusing Patient, Dual Diagnosis Conference, Fuller Memorial Hospital
1989	Treatment of Depression, Massachusetts Medical Society
1991	New Research in Psychosis, Medical Grand Rounds, Mt. Auburn Hospital, Harvard Medical School
1991	Psychopharmacologic Probes in Research on Psychosis, Psychiatry Grand Rounds, Beth Israel Hospital, Harvard Medical School
1991	New Anti-Psychotic Drugs, Massachusetts Psychiatry Society Scientific Meeting
1991	Seminar Leader, Biologic Basis of Schizophrenia, Psychosis Seminar, Beth Israel Hospital, Boston, MA
1991	Treatment-Resistant Psychosis, Psychiatry Grand Rounds, Boston University School of Medicine
1992	Biology of Psychosis, Psychosis Seminar, University of Massachusetts
1993	Seminar Leader, Interface of Psychopharmacology and Psychotherapy, Boston Psychoanalytic Institute
1993	Treatment-Resistant Psychosis, Brighton Marine Public Health Center, Brighton, MA
1993	Treatment-Resistant Psychosis, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1992	New Atypical Neuroleptic Drugs, Neurology Grand Rounds, West Roxbury VA Medical Center
1992	Endocrine Aspects of Psychiatric Disorders, Endocrine Grand Rounds, Brigham & Women's Hospital, Boston, MA
1992	Treatment-Resistant Depression, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1994	Massachusetts Alliance for the Mentally Ill, Brookline Affiliate, Brookline, MA
1994	The New Pharmacology of Schizophrenia, Grand Rounds, Hartford Hospital, CT
1994	The Neurodevelopmental Basis of Schizophrenia, MA Department of Mental Health, Schizophrenia: State-of-the-Art Review Conference, Boston, MA
1994	The New Pharmacology of Schizophrenia, Dartmouth-Hitchcock Medical Center, Dartmouth Medical School, Grand Rounds, Lebanon, NH
1994	New Antipsychotic Medications, Alliance for the Mentally Ill of Cape Cod and the Islands, Hyannis, MA
1995	The New Pharmacology of Schizophrenia, Harvard-Longwood Behavioral Neurology Seminar, Brigham & Women's Hospital, Boston, MA
1995	Should the role of clozapine be expanded? American College of Neuropsychopharmacology, San Juan, PR
1995	New Antipsychotic Drugs, Psychiatry Grand Rounds, Stanford Medical Center
1996	Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1996	An expanded role for clozapine? New Clinical Drug Evaluation Unit Annual Meeting, FL
1996	Psychopharmacology Grand Rounds, McLean Hospital, Belmont, MA
1996	Response to Typical and Atypical Neuroleptics: Clinical Symptoms and Plasma HVA, Schizophrenia and Genetics Conference, Bilbao, Spain
1996	Psychiatry Grand Rounds, Dartmouth Medical School

1997	Psychiatry Grand Rounds, University of Massachusetts Medical Center
1997	Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center, Boston
1997	Psychopharmacology Rounds, Brigham and Women's Hospital, Boston
1997	Psychopharmacology Rounds, McLean Hospital, Belmont, MA
1997	Atypical Antipsychotics in Mood and Other Disorders, Stanford University School of Medicine
1998	Psychopharmacology Rounds, Cambridge Hospital, Cambridge, MA
1998	Psychiatry Grand Rounds, University of Rochester
1998	Novel antipsychotics in psychosis: changing expectations, Program Chair, Industry Symposium, APA annual meeting, Toronto
1998	Substance use disorder and schizophrenia: the role of antipsychotics, APA annual meeting, Toronto
1998	Psychiatry Grand Rounds, University of Vermont
1998	Early Intervention in Psychosis, Neurobiologic Basis. MA Department of Mental Health, Early Interventions in Psychosis Conference, Boston, MA
1999	Psychiatry Research Conference, University of Chicago
1999	Psychopharmacology of Schizophrenia, McLean Hospital
1999	Redefining Treatment-Resistant Schizophrenia, Program Chair and Lecturer, Industry Symposium, APA Annual Meeting, Washington, D.C.
1999	Effects of Antipsychotic-induced Prolactin Elevation, XI World Congress of Psychiatry, Hamburg, Germany
1999	Science Series, Tufts University School of Medicine, Department of Psychiatry
2000	Psychiatry Grand Rounds, University of Toronto.
2000	Psychiatry Grand Rounds, Downstate Medical Center, State University of New York
2000	Peter Curran Lecture, Mater Hospital Trust, Belfast, Northern Ireland
2000	Grand Rounds, Creedmore Psychiatric Center, Queens, New York.
2000	Chair, Gender, Schizophrenia and Antipsychotic Therapy. Second International Conference on Hormones, Brain and Neuropsychopharmacology. Rhodes, Greece
2000	Psychiatry Grand Rounds, Brown University School of Medicine.
2000	Lecturer, Arthur Noyes Schizophrenia Conference, Norristown State Hospital, PA
2000	Lecturer, Schizophrenia and Substance Abuse. Chile Psychiatric Association, La Serena, Chile (via videoconferencing).
2000	Massachusetts Psychiatric Society: Schizophrenia and comorbid substance use disorder.
2000	Treatments for Schizophrenia. Alliance for the Mentally Ill. Framingham, MA
2000	Psychiatry Grand Rounds, University of New Mexico, Albuquerque, NM
2000	Psychiatry Grand Rounds, Brockton VA Medical Center, Harvard Medical School
2001	Meeting the Challenge of Schizophrenia and Co-occurring Addictions, Program Chair. Industry Symposium, APA Annual Meeting
2001	Psychopharmacology of Comorbid Substance Use Disorders, Industry Symposium, APA Annual Meeting
2001	Substance Abuse and Schizophrenia, Satellite Symposium of 7th World Congress on Biological Psychiatry, Berlin, Germany
2001	Psychiatry Grand Rounds, Boston University Medical Center
2001	Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry

2001 Psychiatry Grand Rounds, University of Massachusetts Medical Center
2002 Psychiatry Grand Rounds, Wayne State School of Medicine, Detroit, MI
2002 Psychiatry Grand Rounds, University of Texas Southwestern, Dallas, Texas
2002 Psychopharmacology Conference, Silver Hill Hospital, New Canaan, Connecticut
2002 Research Seminar, Department of Psychiatry, Indiana University Mercer University
2003 Psychiatry Rounds, Harvard University Health Service, Cambridge, MA
2003 Schizophrenia and Substance Abuse, Thresholds Clinic, Chicago, Illinois
2003 Schizophrenia: Past, Present and Future, Central Vermont Medical Center
2003 Addiction Psychiatry Conference, SUNY Upstate Medical University, Syracuse, NY
2003 "Psychiatry and Neuroscience," Brattleboro Retreat Board of Directors, Grafton, VT
2004 Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry, Boston, MA
2004 Psychiatry Grand Rounds, University of Miami, Miami, Florida
2004 Psychiatry Grand Rounds, University of Pennsylvania, Philadelphia, PA
2004 Cannabis, Schizophrenia and Clozapine. Medications Development in Cannabis Dependence, NIDA, Rockville, MD
2004 Schizophrenia and Substance Abuse. Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France
2004 Can You Change the Course of Schizophrenia? Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France
2004 Psychiatry Grand Rounds, Yale Medical School, New Haven, CT
2004 Neuroscience Rounds, McLean Hospital, Harvard Medical School, Belmont, MA
2004 Neuropharmacology Seminar, Albany Medical College, Albany, NY
2004 Special Lecture: "What is Evidence?" McGill Dept of Psychiatry, Montreal, Canada
2004 Keynote Address: "Drugs and the Developing Brain: Adolescent Drug Use." Vermont Substance Abuse Conference, Fairlee, VT
2004 "Neurobiology of Addiction." Annual Scientific Convention, New Hampshire Medical Society, Bretton Woods, NH
2005 Keynote Address: "Early Intervention in Psychosis." NH Chapter of the Psychiatric Nursing Association, Stoweflake, VT
2005 "Substance Abuse and Psychosis." XII International Symposium about Current Issues and Controversies in Psychiatry, Barcelona, Spain
2005 Pharmacotherapy. Substance Abuse and Schizophrenia. Symposium, American Psychiatric Association Annual Meeting, Atlanta, GA
2005 "Drugs and the Developing Brain." Dartmouth Center for Addiction, Research and Education Symposium
2005 "Cannabis and Psychosis." Symposium at American Psychiatric Association Annual Meeting, Atlanta, GA
2005 "Novel Medications Development for Cannabis Dependence Targeting Brain Reward Circuitry." Symposium: Advancing Treatment for Marijuana Dependence. College on Problems of Drug Dependence Annual Meeting, Orlando, FL
2005 "Schizophrenia and Substance Abuse: A Reward Deficiency Syndrome?" Neurology Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, NH
2005 "Schizophrenia and Co-occurring Substance Abuse: A Brain Reward Circuit Deficiency?" Dartmouth Symposium for the Life Science: Mechanisms of Brain Disorders. Dartmouth Hitchcock Medical Center, Lebanon, NH
2005 "Pharmacotherapy for Schizophrenia and Co-occurring Substance Use Disorders." International Meeting on Implications of Comorbidity for Etiology and Treatment of Neuropsychiatric Disorders. Mazagón, Spain

2005 "Current and Emerging Roles for Antipsychotic Therapy," Neuroscience Grand Rounds, University of Arizona, Tucson, AZ

2005 "Substance Abuse and the Vulnerable Brain," Great Issues in Medicine and Global Health Symposium, Dartmouth Hitchcock Medical Center, Lebanon, NH

2006 "Schizophrenia and Substance Abuse." NIDA Symposium on Models of Co-occurring Disorders, Bethesda, MD

2006 "Pharmacologic Approaches to Co-occurring Disorders." NIAAA, NIMH, and NIDA Joint Comorbidity Conference, Bethesda, MD

2006 "Substance Abuse and Schizophrenia." National Conference on Co-occurring Disorders, Indiana University, Indianapolis

2006 "Drugs, Alcohol and Teens." Turner Lecture Series. Sponsored by West Central Behavioral Health, Department of Psychiatry, Dartmouth Medical School, National Alliance for the Mentally Ill.

2006 "The Clinician's Dilemma: When to Use Two Antipsychotics?" I^3dln Teleconference, Atlanta, GA.

2006 "Substance Abuse and the Onset, Severity and Treatment of Schizophrenia." International Society of Addiction Medicine (VIII ISAM Meeting), Oporto, Portugal.

2006 "Schizophrenia and Substance Abuse: Is it all about Reward?" New Frontiers in Psychiatry, Stowe, VT.

2006 Vermont State Substance Abuse Conference, Lake Morey, VT.

2006 "Treatment of Comorbid Cannabis Use and Schizophrenia." American Academy of Child and Adolescent Psychiatry Annual Meeting, San Diego, CA.

2007 Joseph J. Schildkraut Memorial Lecture, University of Massachusetts

2007 Psychiatry Grand Rounds, Vanderbilt University, Nashville, TN.

2008 "Schizophrenia and Substance Abuse: Is it all about rewards?" Psychiatry Grand Rounds, Maine Medical Center, Portland, ME.

2008 "Deconstructing Clozapine: Toward New Medications for Alcoholism." NIAAA, Washington, DC.

2008 "Schizophrenia and Substance Abuse: Is it all about rewards?" Psychiatry Grand Rounds, Tufts Medical Center, Boston, MA.

2008 "Lifting the Veil on Mental Illness: Science in Psychiatry." Dartmouth Community Medical School

2008 "Targeting Reward Circuitry: Medication Development for Schizophrenia and Substance Abuse." 1st Annual Chairs Summit, Hilton Head Island, SC. June 27-29.

2009 "Schizophrenia and Substance Abuse: Approaching Pharmacotherapy." Plenary Session, CINP Thematic Conference, Edinburgh, UK. April 25-27.

2009 "A Translational Perspective on Clozapine: Clinical Utility." CINP Thematic Conference, Edinburgh, UK. April 25-27.

2009 "Update on the Pharmacologic Treatment of Schizophrenia." American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.

2009 "Treatment of Schizophrenia and Co-Occurring Alcoholism." American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.

2009 "Cannabis and Psychosis." Australian National Cannabis Conference, Sydney, Australia. September 7-8.

2009 "Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia." Psychiatry Grand Rounds, McMaster University, Hamilton, ON, Canada. September 16.

2009 "Cannabis and Schizophrenia" October 27-November 1. American Association of Child and Adolescent Psychiatry Annual Meeting. Honolulu, HI.

2010 "Concurrent Treatment of Cannabis Dependence in Patients with Schizophrenia."
American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.

2010 "Non-Psychotic Issues of Schizophrenic Patients: Schizophrenia and Substance Abuse."
American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.

2010 "Treatment of Schizophrenia and Co-Occurring Alcoholism"
Research Society on Alcoholism Annual Meeting, San Antonio, TX. June 26-30.

2010 "Essential Psychopharmacology, 2010: Practice and Update"
Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 2-6.

2011 "Essential Psychopharmacology, 2011: Practice and Update"
Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 1-5.

2011 "Deconstructing Clozapine: Toward Medications for Schizophrenia and Substance Abuse."
CINP (Collegium Internationale Neuro-Psychopharmacologicum)
International Congress on Dual Disorders. Barcelona, Spain. October 4.

2011 "Does Use of Cannabis Increase Risk or Speed the Onset of Psychosis?"
2011 Course on the State of the Art in Addiction Medicine. October 27-29.
American Society of Addiction Medicine, Washington, DC

2012 "Double Trouble: Co-occurrence of Alcoholism and Psychiatric Disorders."
American Psychiatric Association. Philadelphia, PA. May 7, 2012.

2012 "Essential Psychopharmacology, 2012: Practice and Update"
Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). Jul 31-Aug 3.

2013 "Schizophrenia and Co-Occurring Substance Use Disorders: Exploring Common Neurocircuits and Effective Treatments: NIAAA Panel Session."
New clinical Drug Evaluation Unit of NIMH. Hollywood Beach, FL, May 29.

2013 "Deconstructing Clozapine: Toward Medications for Schizophrenia and Substance Abuse."
Penn State Medical Center. Hershey, PA, September 19.

2013 "Use of Antipsychotics and Dual Pathology." International Congress. Spanish Society of Dual Pathology. Barcelona, Spain, October 25.

2014 "Substance Abuse in Schizophrenia: Targeting the Brain Reward Circuit" Neuroscience Day at Dartmouth. Lebanon, NH, February 21.

2014 "Brain Reward Circuit Activity: An Indicator of Therapeutic Efficacy?" Neurology Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, NH, May 9.

2014 "Cannabis Use Disorder in Schizophrenia: Is this really self-medication?" 8th ALBATROS Congress, International Congress of Addictology. Paris, France, June 5.

2014 "Psychosis and Co-occurring Substance Use Disorder: Neural Circuitry, Models and New Treatment Development." International Society for Biomedical Research on Alcoholism/Research Society on Alcoholism Joint Congress, Bellevue, WA, June 24.

2014 "Antipsychotics, Biology and Treatment of Schizophrenia"
Harvard Medical School Summer Seminar, July 28.

2015 "Journal of Dual Diagnosis"
"Substance Use and Schizophrenia: Risk and Reward"
"Cannabis Use in Schizophrenia"
"Clozapine for Substance Use Disorders in Schizophrenia: A Unifying Hypothesis?"
International Congress of Dual Disorders, Addictions and Other Mental Disorders.
Barcelona, Spain, April 17-20.

2015 "Alcohol Use Disorder and Schizophrenia: Approaches to Pharmacologic Interventions"
American Psychiatric Association. Toronto, Ontario, May 16.

2017 "Schizophrenia and Co-occurring Substance Use Disorders: Translational Research and Reward" World Conference of the World Association of Dual Disorders & International

Congress of the Spanish Society of Dual Disorders. Madrid, Spain, March 24.

2017 "Biology and treatment of psychotic disorder"
Harvard Medical School Summer Seminar, August 1.

2017 "Concepts of early intervention and prevention; optimizing outcomes; treatment of alcohol and substance abuse in patients with psychosis.
Harvard Medical School Summer Seminar, August 1.

2018 "Schizophrenia and Substance Use Disorder: A Unifying Hypothesis" Schizophrenia International Research Society, Florence, Italy, April 4-8.

Formally Supervised Trainees (and current position)

1987 – 1990 Mohammed Y Alam, M.D. (Post-doctoral Fellow)
Staff Psychiatrist, American Medical Research, Inc., Oak Brook, IL

1991 – 1993 Ileana Berman, M.D. (Post-doctoral Fellow)
Private Practice, Attleboro, MA

1991 – 1993 Howard H. J. Chang, M.D., M.P.H. (Post-doctoral Fellow)
Psychiatrist, South Shore Hospital, Weymouth, MA

1993 – 1995 Jayendra K. Patel, M.D. (Post-doctoral Fellow)
Private Practice, Lake Charles, LA

1994 – 1998 Rahim Shafa, M.D. (Post-doctoral Fellow)
Director, Novel Clinical Psychopharmacology Care, Natick, MA
Staff Psychiatrist, Metrowest & Greater Boston CNS Research Center

1995 – 1997 Carla Canuso, M.D. (Post-doctoral Fellow)
Senior Director of Neuroscience External Innovation at Johnson & Johnson

1997 – 1999 James Kelleher, M.D. (Post-doctoral Fellow)
Associate Professor, Clinical Psychiatry and Behavioral Sciences,
New York Medical College

1998 – 1999 Carmela Perez, Ph.D. (Post-doctoral Fellow)
Private Practice Psychoanalyst, New York, NY
Assistant Professor of Psychiatry, St. Vincent's Hospital
Assistant Professor of Psychiatry, New York Medical College

1998 – 2000 Rael Strous, M.D. (Post-doctoral Fellow)
Professor of Psychiatry, Sackler School of Medicine, Tel Aviv University.
Senior Psychiatrist, Be'er Ya'aqov Mental Health Center, Tel Aviv.

1998 – 2001 Jaskaran Singh, M.D. (Post-doctoral Fellow)
Senior Director, Clinical Research, Neuroscience at Janssen,
Johnson & Johnson Pharmaceutical Research and Development, San Diego, CA

1999 – 2001 Michael Rodriguez, Ph.D. (Post-doctoral Fellow)
Assistant Professor, Department of Psychology, Harvard University

2000 – 2001 Amani Michael, M.D. (Post-doctoral Fellow)
Psychiatrist, Integrated Behavioral Associates, Weymouth, MA

2000 – 2001 Wilson Woo, M.D., Ph.D. (Post-doctoral Fellow)
Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA.
Director, Laboratory of Cellular Neuropathology, McLean Hospital, Boston, MA
Medical Director, Harvard Brain Tissue Resource Center,
Beth Israel Deaconess Medical Center, Boston, MA.

2001 – 2003 David Chau, Ph.D. (Post-doctoral Fellow)
Founder and President of Amazing Grace Pharmaceuticals

2002 – 2006 Vivianne Tawfik, M.D., Ph.D. (Pre-doctoral Student)
Instructor, Anesthesiology, Perioperative and Pain Medicine
Stanford School of Medicine, Stanford, CA.

2005 – 2006 Timothy Laumann (Dartmouth Undergraduate)
M.D. Ph.D. student, Washington University, St. Louis

2007 – 2010 Matthew Garlinghouse, Ph.D. (Post-doctoral Fellow)
Senior Neuropsychologist at Henry Ford Health Systems, Detroit, MI.

2007 – 2010 Michael Henderson, J.D. (Pre-doctoral Student)
Associate University Counsel, Temple University, Philadelphia, PA.

2009 – 2010 Victoria Stockman (Dartmouth Undergraduate)
PhD Student, Department of Systems Biology,
Columbia University Graduate School of Arts and Sciences, New York, NY.

2009 – 2011 Danielle Gulick, Ph. D. (Post-doctoral Fellow)
Assistant Professor, Morsani College of Medicine, University of South Florida

2009 – 2011 Natalie Colaneri (Dartmouth Undergraduate)
Visiting Researcher, Oxford Uehiro Centre for Practical Ethics,
University of Oxford, England.

2010 – 2011 Eric Arehart, M.D. Ph.D. (Post-doctoral Fellow)
Resident, Neurology, Duke Children's Hospital & Health Center, Durham, NC.

2010 – 2012 Yip Wong, B.S. (Pre-doctoral Fellow – Program in Experimental Molecular Medicine)

2010 – 2013 Adina Fischer, M.D., Ph.D. (Pre-doctoral Fellow)
Resident Physician, Psychiatry and Research Track, Stanford University

2011 – 2013 Sarah Aronson (Dartmouth Undergraduate)
MD-PhD Candidate, University of Maryland School of Medicine

2011 – 2013 Jill MacLeod, Ph.D. (Post-doctoral Fellow)
Biotoxin Monitoring, State of Maine Department of Marine Resources

2013– 2013 Jaime Bravo (Dartmouth Graduate Rotating Student)
Graduate Student in Biomedical Engineering, Dartmouth College

2011 – 2013 Wilder Doucette, M.D., Ph.D.
Assistant Professor of Psychiatry, Geisel School of Medicine

2012 – 2017 Jibran Khokhar, Ph.D. (Post-doctoral Fellow)
Department of Psychiatry, Postdoctoral Fellowship

2013 – 2015 Sarah C. Akerman, M.D.
Assistant Professor of Psychiatry, Geisel School of Medicine at Dartmouth

2013 – 2016 Hersh Trivedi
Dartmouth Undergraduate Student

2013 – Michael Sun
Dartmouth Undergraduate Student

2013 – ? Mia Harrow-Mortelliti
Dartmouth Undergraduate Student

2014 – 2016 Nicholas Deveau
Dartmouth Undergraduate Student

2014 – 2014 David Mallick
Dartmouth Graduate Rotating Student

2014 – 2016 Jared Boyce
Dartmouth Undergraduate Student

2015 – 2017	Amanda Simon Dartmouth Undergraduate Student
2015 – 2017	Megan Cheng Dartmouth Undergraduate Student
2015 – 2015	Carey Allmendinger Dartmouth Graduate Rotation Student
2015 –	Rebecca Zegans Wesleyan Undergraduate Student
2015 –	Robert Tokhunts Dartmouth Medical Student
2015-	Lucas Dwiel (graduate student) Dartmouth Program in Experimental and Molecular Medicine
2016-	Angela Hendricks (Post-doctoral fellow) NIDA T32 Fellowship on Dual Disorders
2017-	Emily Kirk (Graduate Student) Dartmouth Medical Student
2017-	Diana Wallin (Post-doctoral Fellow)

Bibliography

Articles

1. Snyder SH, Green A, Hendley ED, Gfeller E. Noradrenaline: kinetics of accumulation into slice from different regions of rat brain. Nature. 1968; 218: 174-176.
2. Snyder SH, Green AI, Hendley ED. Kinetics of H3-norepinephrine accumulation into slices from different regions of the rat brain. J. Pharmacol. Exp. Ther. 1968 Nov; 164: 90-102.
3. Gfeller E, Green AI, Snyder SH. Regional differences in noradrenaline accumulation in monkey brain. Brain Research. 1968; 11: 263-267.
4. Green AI, Snyder SH, Iversen LL. Separation of catecholamine storing synaptosomes in different regions of rat brain. J. Pharmacol. Exp. Ther. 1969 Aug; 168(2): 264-271.
5. Kuhar M, Green AI, Snyder SH, Gfeller E. Separation of synaptosomes storing catecholamines and gamma-aminobutyric acid in rat corpus striatum. Brain Research. 1970 Jul; 21: 405-417.
6. Green AI. The role of the federal government in the development of narcotic antagonists. Adv Biochem Psychopharmacol. 1973; 8(0): 576-7.
7. Green AI. Thyroid function and affective disorders. Hosp Commun Psych 1984 Dec; 35: 1188-9.
8. Salzman C, Green AI, Rodriguez-Villa F, Jaskiw GE. Benzodiazepines combined with neuroleptics for management of severe disruptive behavior. Psychosomatics. 1986 Jan; 27: 17-22.
9. Green AI, Brown WA. Prolactin and neuroleptic drugs. Endocrin. Metabol. Clin. N. Amer. 1988 Mar; 17(1): 213-223. [Reprinted in: Neurologic Clinics. 1988 Feb; 6(1): 213-223.
10. Green AI. The Biology of Depression: book review. American J. of Psychiatry. 1989; 146: 390.
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279. Green AI, Brunette M, Noordsy D, Roth R. Treatment of comorbid cannabis use and schizophrenia. AACAP Annual Meeting Scientific Proceedings, 2006.

280. Green AI, Hamer RM, Woolson SL, Tohen M, Lieberman JA, HGDH Study Group. First episode psychosis and substance abuse: a two-year efficacy trial of olanzapine vs. haloperidol. American College of Neuropsychopharmacology Annual Meeting Abstracts. Neuropsychopharmacology, 2006; 31(Suppl 1): S112.

281. Green AI, Chau DT, Henderson MB, Ahmed J. Clozapine for alcohol abuse in schizophrenia: insights from clinical and animal studies, American College of Neuropsychopharmacology Annual Meeting Abstracts, 2007, 30.

282. Green AI, Hamer RM, Woolson SL, Tohen M, Lieberman JA, HGDH Study Group. First episode psychosis and substance abuse: a two-year efficacy trial of olanzapine vs. haloperidol. Abstracts for the 11th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2007; 33(2): 431.

283. Chau DT, Green AI. Clozapine for alcohol abuse in schizophrenia: Insights from animal studies. Research Society on Alcoholism Annual Conference abstracts. Alcoholism-Clinical and Experimental Research, 2008: 32(6):84A.

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285. Green AI. Early Detection and Treatment of Schizophrenia with Co-occurring Cannabis Use Disorder. American Academy of Child and Adolescent Psychiatry Annual Meeting Abstract. 2009.

286. Green AI, Brunette MF, Dawson R, Narasimhan M, Wallace A, Herz M, Sommi R, Buckley P, R-LAST Study Team. Oral vs. Long-acting Injectable Risperidone in Schizophrenia and Co-Occurring Alcohol Use Disorder. American College of Neuropsychopharmacology Annual Meeting Abstracts. Neuropsychopharmacology, 34, 2009.

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289. Brunette M, Green AI, Buckley PF, O'Keefe C, Dawson R. Quetiapine for the Treatment of Patients with Schizophrenia and Alcohol Use Disorders. Abstracts for the 12th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2009: 35(suppl 1): 371.
290. Gulick D, Chau DT, Green AI. Clozapine decreases alcohol consumption but not sucrose consumption in Syrian Golden hamsters. Society for Neuroscience Annual Meeting 2009 Abstracts.
291. Gulick D, Chau D, Ahmed J, Wang T, Xie H, Dawson R, Green A. Raclopride Lessens the Ability of Clozapine to Suppress Alcohol Drinking in Syrian Golden Hamsters. American College of Neuropsychopharmacology Annual Meeting Abstracts. Neuropsychopharmacology, 35, 2010: S285.
292. Gulick D, Green AI. Role of caloric content and reward value in the consumption of alcohol by the Syrian golden hamster. Program No. 66.4. 2010 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2010. Online.
293. Noordsy D, Smith JN, Green AI. Clozapine vs. Risperidone for People with First Episode Schizophrenia and Co-Occurring Cannabis Use Disorder. Second Biennial Schizophrenia International Research Society Conference. Schizophrenia Research, 2010, 117(2): 165-166.
294. Liebman HM, Pietersen CY, Thermenos H, Seidman LJ, Green AI, Woo TUW. The addition of tiagabine to antipsychotic medication in the treatment of recent-onset schizophrenia by modification of developmental pruning of prefrontal circuitry. Program No. 880.26. 2010 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2010. Online.
295. Abdel-Fadeel NAM, McCarley R, Mesholam-Gately R, Wojcik J, Green A, Goldstein JM, Seidman LJ. Gender Differences in Clinical Presentation of First Episode Psychosis: Relationship to Premorbid Adjustment. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 275.
296. Green A, Chau DT, Gulick D, Ahmed J, Epstein K, Dawson R. Deconstructing clozapine: Toward medication development for alcoholism in schizophrenia. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 288.
297. Brunette MF, Dawson R, O'Keefe CD, Narasimhan M, Noordsy D, Wojcik J, Green AI. Clozapine vs. other antipsychotics for schizophrenia and co-occurring cannabis use disorder. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 297.
298. Shaskan NK, Thermenos HW, Seidman LJ, Green A, Woo TUW. The addition of tiagabine to antipsychotic medication in the treatment of recent-onset schizophrenia by modification of developmental reorganization of prefrontal circuitry. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 320.
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301. Gulick D, Templeton E, Green AI. Delta-9-tetrahydrocannabinol decreases alcohol intake in the Syrian golden hamster. Program No. 427.04. 2011 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2011. Online.

302. Gulick D, Bonvini L, Templeton E, Sonstegard A, Bucci DJ, Green AI. Clozapine inhibition of alcohol intake in Syrian Golden Hamsters: Selectivity, Motivation and Reward. Program No. 869.14. 2012 Neuroscience Meeting Planner. New Orleans, LA: Society for Neuroscience, 2012. Online.

303. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Effects of cannabis and THC on resting state functional connectivity of the brain reward circuit in patients with schizophrenia and cannabis use disorder. Program No. 867.10. 2012 Neuroscience Meeting Planner. New Orleans, LA: Society for Neuroscience, 2012.

304. Green AI, Fischer AS, Roth RM, Whitfield-Gabrieli S, Gulick D, Brunette M. Developing Treatments for Schizophrenia and Co-occurring Substance Use Disorder: Targeting Brain Reward Circuitry. New Clinical Drug Evaluation Unit, 53rd annual meeting, 2013. Online.

305. Green AI, Fischer AS, Roth RM, Whitfield-Gabrieli S, Gulick D, Brunette, M. Developing treatments for schizophrenia and co-occurring substance use disorder: Targeting brain reward circuitry. Bethesda, MD: National Institute of Mental Health Annual Conference, 2013.

306. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Effects of Smoked Cannabis and Oral Delta-9-tetrahydrocannabinol on Functional Connectivity of Reward Circuitry in Patients with Schizophrenia. Proceedings of the 2013 American Neuropsychiatric Association Annual Meeting. The Journal of Neuropsychiatry and Clinical Neurosciences, 2013; 25(2): 161-166.

307. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Resting state functional connectivity of the brain reward circuit in patients with schizophrenia and cannabis use disorder. Schizophrenia Bulletin Proceedings of the 14th International Congress on Schizophrenia Research. 2013; 39(Suppl 1): 30-31.

308. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Alterations in functional connectivity of reward circuitry induced by cannabis and THC in patients with schizophrenia and cannabis use disorder. 13th International Congress on Schizophrenia Research, Orlando, FL, 2013.

309. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Effects of smoked cannabis and oral delta-9-tetrahydrocannabinol on functional connectivity of the brain reward circuit in patients with schizophrenia. American Neuropsychiatric Association Annual Meeting, Boston, MA, 2013.

310. Fischer AS, Whitfield-Gabrieli S, Roth RM, Green AI. Cannabinoid agonists, functional connectivity of the default mode network, and working memory performance in patients with schizophrenia and cannabis use disorder. American College of Neuropsychopharmacology 53rd Annual Meeting, Phoenix, AZ, 2014.

311. Fischer AS, Whitfield-Gabrieli S, Roth RM, Green AI. Cannabis and THC: Effects on intrinsic functional brain organization of the default mode network in patients with schizophrenia and cannabis use disorder. Society of Biological Psychiatry: 69th Annual Scientific Meeting, New York, NY, 2014.

312. Fischer AS, Whitfield-Gabrieli S, Roth RM, Brunette MF, Green AI. Delineating brain reward circuit abnormalities in patients with schizophrenia and cannabis use disorder – a resting state functional connectivity (rs-fcMRI) approach. Poster presented at: 4th Biennial Conference on Resting State Brain Connectivity, Boston, MA, 2014.

313. Whitfield-Gabrieli S, Fischer AS, Roth RM, Green AI. Functional connectivity of the default mode network in patients with schizophrenia and the effects of cannabinoid agonist administration. Poster presented at: 4th Biennial Conference on Resting State Brain Connectivity, Boston, MA, 2014.

314. Khokhar, J., Green, A. Deconstructing clozapine further: Toward medication for alcohol use disorder in schizophrenia. Neuroscience Research Day, Lebanon, NH, 2014.

315. Khokhar, J., Green, A. Deconstructing clozapine further: Toward medication for alcohol use disorder in schizophrenia. Biological Psychiatry, 2014, 75 (9): 393S.

316. Khokhar, J., Green, A. Lessons from Clozapine: Toward treatment development for alcohol use disorder in schizophrenia. Research Society on Alcoholism, Bellevue, WA. Alcoholism: Clinical and Experimental Research, 2014, 38: 333A.

317. Khokhar, J., Green, A. Deconstructing clozapine further: Toward medication for alcohol use disorder in schizophrenia. CPDD San Juan Puerto Rico. Drug and Alcohol Dependence, In press.

318. Green AI. Alcoholism in patients with schizophrenia: A unifying hypothesis? Research Society on Alcoholism. 2014.

319. Fischer AS, Whitfield-Gabrieli S, Roth R, Green AI. Improvement in anti-correlation between regions of the "task positive" and default mode and networks induced by cannabis and THC in patients with schizophrenia: Implications for working memory? International Congress on Schizophrenia Research, Colorado Springs, Colorado, 2015.

320. Green AI. Alcohol and Schizophrenia: Approaches to Pharmacologic Intervention. American Psychiatric Association, Toronto, Ontario, 2015.

321. Green AI. Substance Use and Schizophrenia: Risk and Reward. International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.

322. Green AI. Cannabis Use in Schizophrenia. International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.

323. Green AI. Clozapine for Substance Use Disorders in Schizophrenia: A Unifying Hypothesis? International Congress of Dual Disorders, Addictions and Other Mental Disorders. Barcelona, Spain, 2015.

324. Khokhar JY, Chen X, Lu H, Gimi B, Stein EA, Green AI. Impaired Brain Reward Circuitry May Underlie Alcohol Drinking in a Rat Model of Schizophrenia and Co-Occurring Alcohol Use Disorder. American College of Neuropsychopharmacology. Hollywood, Florida, 2016.

325. Khokhar J, Todd T, Doucette W, Bucci D, Green A. Long-Lasting Impact of Adolescent Cannabinoid Exposure on Reward-Related Behaviors: Potential Interaction with Schizophrenia. First World Congress of the World Association on Dual Disorders & Fifth International Congress of the Spanish Society on Dual Disorders. Madrid, 2017.

326. Khokhar J, Chin X, Lu H, Barjor G, Stein E, Green AI. Impaired Brain Reward Circuitry May Underlie Alcohol Drinking in a Rat Model of Schizophrenia and Co-Occurring Alcohol Use Disorder. First World Congress of the World Association on Dual Disorders & Fifth International Congress of the Spanish Society on Dual Disorders. Madrid, 2017.

327. Brunette MF, Correll CU, O'Malley SS, Silverman BL, Simmons A, Jiang Y, DiPetrillo L, McDonnell D, Citrome L, Green AI. A Phase II, Randomized Double-Blind Study of ALKS 3831 in Schizophrenia and Co-Occurring Alcohol Use Disorder. American Society of Clinical Psychopharmacology Annual Meeting. Miami Beach, Florida, 2018.

Susan Gingerich, MSW

EDUCATION

1978 - 1980 Simmons School of Social Work, Boston, Massachusetts. M.S.W.

1971 - 1975 Wellesley College, Wellesley, Massachusetts. B.A. in Psychology.

PROFESSIONAL POSITIONS

10/03 to present — Independent Consultant and Trainer, Philadelphia, PA.
Providing workshops and follow-up consultation for Illness Management and Recovery (IMR), Recovery After an Initial Schizophrenia Episode (RAISE), NAVIGATE Early Treatment Program, Social Skills Training, Helping Individuals Reduce Relapses, and Working with Families of Persons with Mental Illness.

3/2014 to present — Coordinator of training for NAVIGATE Early Treatment Program

10/2012 to present — Boston University, Boston, MA
Member of the development team and trainer for Health Technology Program, part of a grant from Center for Medicare and Medicaid Improvement (CMMI) for using technology to help improve mental health and prevent hospitalizations.

10/00 to 2013 — New Hampshire-Dartmouth Psychiatric Research Center, Concord, NH.
Co-chair of the development team and trainer for the following:
IMR (Illness Management and Recovery), part of SAMHSA'S Evidence-Treatment Practices toolkit project
NAVIGATE Treatment Model, part of the RAISE (Recovery After an Initial Schizophrenia Episode) multi-site NIMH project
Relapse Prevention Planning component of The Health Technology Program, part of the Improving Care and Reducing Costs project, sponsored by CMMI (Center for Medicare and Medicaid Innovation).

1/96 – 1/02 — Delaware Psychiatric Center, Newcastle, Delaware.
Psychiatric Rehabilitation Consultant.

10/89-10/96 — Eastern Pennsylvania Psychiatric Institute, Philadelphia, Pennsylvania.
Social Skills Trainer and Research Associate for the Educational Family Therapy Program

12/88-1/91	New York State Psychiatric Institute, New York, New York. Supervisor/consultant for Multiple Family Education groups, conducted as part of Family Support Demonstration Project (William McFarlane, MD).
12/87-7/89	Hillside Hospital, Long Island Jewish Medical Center, Glen Oaks, New York. Mt. Sinai Hospital, New York, New York. Research clinician for Post-Psychotic Depression Study (Sam Siris, MD).

PUBLICATIONS

2013	Mueser, K.T., Gottlieb, J.D., & Gingerich, S. Social skills and problem solving training. In S.G. Hoffman (Ed.), Wiley Handbook of Cognitive Behavioral Therapy (pp. 243-271). New York: Wiley.
2013	Mueser, K.T., & Gingerich, S. Treatment of co-occurring psychotic and substance use disorders. Social Work in Public Health, 28, 424-39.
2011	Mueser, K.T., & Gingerich, S. Relapse prevention and recovery in patients with psychosis: The role of psychiatric rehabilitation. Psychiatric Times, 28(6), 66-71.
2011	Mueser, K., & Gingerich, S. Collaborating with Families of People with Serious Mental Illness. In Rudnick, A. and Roe, D. (Editors). Serious Mental Illness: Person-Centered Approaches. NY, NY: Radcliffe Publishing.
2011	Gingerich, S. & Mueser, K. Illness Management and Recovery: Personalized Skills and Strategies for Those with Mental Illness. (Client handouts, Practitioner Session-by-Session Guidelines, Implementation Guide, CD-ROM, DVD of introduction and practitioner training vignettes). Center City, MN: Hazelden Publications.
2011	Mueser, S. & Gingerich, S. Illness Management and Recovery. In Vandiver, V. (Ed.). Best Practices in Mental Health: A Pocket Guide. New York, NY: Oxford University Press.
2011	Mueser, K.T., & Gingerich, S. Illness self-management programmes. In G. Thornicroft, G. Szmukler, K.T. Mueser, & R.E. Drake (Eds.), Oxford Textbook of Community Mental Health. Oxford, England: Oxford University Press (pp. 211-219
2010	Meyer, P., Mueser, K. & Gingerich, S. A guide to implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, Springer, and Trawver (Eds.), Psychosocial treatment of Schizophrenia. New York, NY: Wiley.

2009 Whitley, R.E., Gingerich, S., Lutz, W.J., & Mueser, K.T. Implementing the Illness Management and Recovery program in community mental health settings: Facilitators and barriers. Psychiatric Services, 60, 202-209.

2009 Gingerich, S. Guidelines for social skills training for persons with mental illness. In Social Workers' Desk Reference, second edition. Roberts, A. & Greene, G., editors. Oxford Press.

2008 Mueser, K. & Gingerich, S. Illness self-management training. In Clinical Handbook of Schizophrenia. Mueser, K. and Jeste. D, editors. Guilford Press

2008 Gingerich, S., & Mueser, K.T. (2008). Illness Management and Recovery (IMR): An evidence-based practice that can benefit persons with schizophrenia, bipolar disorder and major depression. Society for Social Work Leadership in Healthcare Newsletter, 10 (6), 2-3, 8.

2008 Mueser, K. & Gingerich, S. Making Choices: Substances and You. Module 7 in Team Solutions. Eli Lilly and Company. Available at www.treatmentteam.com.

2007 Gingerich, S. & Mueser, K. Family intervention for severe mental illness. In Cognitive Behavior Therapy in Clinical Social Work Practice. Ronen, T. and Freeman, A. editors. New York: Springer Publishers.

2006. Mueser, K., & Gingerich, S. The Complete Family Guide to Schizophrenia. Guilford Press. Winner of NAMI Ken Book Award.

2005 Gingerich, S. & Mueser, K. Illness Management and Recovery. In Evidence-Based Practices in Mental Health: A Textbook. Merrens, M., et al., editors. W.W. Norton.

2005 Gingerich, S, & Mueser K. Coping Skills Group: A Session-by-Session Guide. Wellness Reproductions.

2005 Mueser, K.T., & Gingerich, S. Illness Management and Recovery (IMR) Scales. In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H.S. Leff (Eds.), Measuring the Promise: A Compendium of Recovery Measures (Vol. II). Cambridge, MA: Evaluation Center @ Human Services Research Institute.

2004 Bellack, A., Mueser, K., Gingerich, S., & Agresta, J. Social Skills Training for Schizophrenia, second edition. Guilford Press.

2002 Mueser, K., Corrigan, P., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S., Essock, S., Tarrier, N., Morey, B., Vogel-Scibilia, S., & Herz, M. Illness management and recovery: A review of the research. Psychiatric Services 53 (10). 1272-1284.

2002	McFarlane, W., Gingerich, S., Deakins, S., Dunne, E., Horen, B., & Newmark, M. Co-author of four chapters in Multiple Family Groups in the Treatment of Severe Psychiatric Disorders by William McFarlane. Guilford Press.
2002	Gingerich, S. Guidelines for social skills training for persons with mental illness. In Social Workers' Desk Reference, First Edition. Roberts, A. & Greene, G., editors. Oxford Press.
2002	Gingerich, S. Social workers as crisis counselors. In Social Workers in Mental Health Practice. Kia Bentley, editor. Wordsworth-Brooks/Cole.
1998	Gingerich, S. Stigma: Critical issues for clinicians assisting individuals with severe mental Illness. Cognitive and Behavioral Practice 5 (13): 277-285.
1997	Bellack, A., Mueser, K., Gingerich, S., & Agresta, J. Social Skills Training For Schizophrenia. New York: Guilford Press.
1995	Gingerich, S. & Bellack, A. Research-based family interventions for the treatment of schizophrenia. Clinical Psychologist 48 (1): 24-27.
	Reprinted in Research on Social Work Practice 6 (1): 122-126.
1994	Mueser, K. & Gingerich, S. Coping with Schizophrenia: A Guide for Families. Oakland: New Harbinger Publications.
1994	Mueser, K., Gingerich, S., & Rosenthal, C. Educational family therapy for schizophrenia: a new treatment model for clinical service and research. Schizophrenia Research 13: 99-108.
1993	Mueser, K., Gingerich, S., & Rosenthal, C. Familial factors in psychiatry. Current Opinion in Psychiatry 6: 251-257.
1990	Mason, S., Gingerich, S., & Siris, S. Patients and caregivers' adaptation to improvement in schizophrenia. Hospital and Community Psychiatry 41(5): 541-544.
	Reprinted in Critical Strategies for Academic Thinking and Writing, Boston: Bedford Books of St. Martin's Press, 628-634.
1989	Siris, S., Cutler, J., Owen, A., Mason, S., Gingerich, S., & Lang, M. Controlled trial of adjunctive imipramine maintenance in schizophrenic patients with remitted post-psychotic depressions. American Journal of Psychiatry 146: 1495-1497.
1988	Falloon, I., Gingerich, S., Mueser, K., Rappaport, S. McGill, C., & Hole,V. Behavioral Family Therapy: A Workbook. Buckingham, England: FACTS Press.

1983 — Vannicelli, M., Gingerich, S., & Ryback, R. Family problems related to the treatment and outcome of alcoholic patients. British Journal of Addictions.

MANUALS

2013 — Gingerich, S., Meyer, P., & Mueser, K. Relapse Prevention Planning manual for the Health Technology Program (part of a grant from CMMI, the Center for Medicaid and Medicare Improvement)

2013 — Gingerich, S., Miller, J., Monroe-Devita, M., Mors, G., Mueser, K., & Hamilton, A. ACT+IMR: Integrating Illness Management and Recovery into Assertive Community Treatment Teams.

2013 — Meyer, P., Gingerich, S., Fox, L., & Mueser, K. Minnesota Clinical Competency Scale for Enhanced IMR for Co-occurring Disorders, First Edition.

2011 — Overall co-editor and contributing author to the following RAISE-Early Treatment Program manuals: Individual Resiliency Training, Family Education Program, Supported Employment and Education, and Team Members' Guide.

2009 — Gingerich, S., Arnold, K. & Mueser, K. The Happy, Healthy Life Group (an Adaptation of the Illness Management and Recovery Toolkit for Persons with Mental Illness and Intellectual Disabilities and/or Cognitive Challenges).

2007 — Meyer, P., Gingerich, S., & Mueser, K. Minnesota IMR Clinical Competency Scale.

2006 — Gingerich, S. & Agresta, J. Multiple Family Groups for Adolescents with Mood Disorders.

2002 — Gingerich, S., & Mueser, K., Illness Management and Recovery: Implementation Toolkit . Substance Abuse and Mental Health Services Administration.

2001 — Gingerich, S. Conducting Groups for Clients in an Inpatient Psychiatric Facility.

1994 — Bellack, A., Gingerich, S., Agresta, J. & Mueser, K. Social Skills Training for Psychiatric Clients with Persistent Symptoms.

1991 — Mueser, K., Gingerich, S. & Rosenthal, C. Educational Family Therapy.

1989 — McFarlane, W., Deakins, S., Gingerich, S., Horen, B., & Newmark, M. Conducting Multiple Family Psychoeducational Groups.

Curriculum Vitae

DELBERT GAIL ROBINSON, M.D.

EDUCATION AND TRAINING

	1971-1975	Vanderbilt University, Nashville, TN B.A., Molecular Biology, 1975.
GRADUATE	1976-1979	The University of Tennessee Center for the Health Sciences, Memphis,TN, M.D., 1979.
POST-GRADUATE	1979-1980	The Mary Hitchcock Memorial Hospital Dartmouth College, Hanover, New Hampshire Internship.
	1980-1983	Western Psychiatric Institute and Clinic, University of Pittsburgh, PA Resident: General Psychiatry.
	7/83-6/85	College of Physicians & Surgeons Columbia University, NY, NY Research Fellow

PROFESSIONAL EMPLOYMENT AND HOSPITAL APPOINTMENTS :

7/82-7/83	Affective Disorders Module Western Psychiatric Institute and Clinic Chief Resident
1984/6/85	College of Physicians & Surgeons Columbia University, NY, NY Instructor in Clinical Psychiatry
1984-6/85	Columbia Presbyterian Medical Center, NY, NY Assistant Psychiatrist
7/85-12/85	Downstate Medical School, Brooklyn, NY Assistant Professor of Clinical Psychiatry
7/85-12/85	Kings County Hospital, Brooklyn, NY Chief, Medical Student Teaching Ward
1/86-present	The Zucker Hillside Hospital, division of North Shore Long Island Jewish Health System

Glen Oaks, NY
Research Psychiatrist

1/91-1/99 The Zucker Hillside Hospital, division of
North Shore Long Island Jewish Health System
Glen Oaks, NY
Chief, Obsessive Compulsive Disorders Program

1/91-2004 The Zucker Hillside Hospital, division of
North Shore Long Island Jewish Health System
Glen Oaks, NY
Chief, Clinical Assessment and
Training Unit of the Clinical Research Center for the Study of Schizophrenia

1/96-1/98 The Zucker Hillside Hospital, division of
North Shore Long Island Jewish Health System
Glen Oaks, NY
Acting Co-Director, Clinical Research Center for the Study of Schizophrenia

1/96-1/99 The Zucker Hillside Hospital, division of
North Shore Long Island Jewish Health System
Glen Oaks, NY
Co-Director, Psychopharmacology Unit of the Clinical Research Center for the Study of Schizophrenia

1/01-Present Feinstein Institute for Medical Research
North Shore-Long Island Jewish Health System
Associate Investigator

11/03-6/05 Co-Director, Scientific Direction And Administration Unit, Intervention Research Center for Course of Illness in Schizophrenia: Optimizing Outcomes.

7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes
Co-Director

7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes
Co-Director, Scientific Direction and Administration Unit

7/05-Present The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes/Early Phase Psychosis: Informing Treatment Decisions
Co-Director, Trials Operation Unit

7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes
Co-Director, Research Network Development Core

7/05-6/10 The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes
Director, Functional Outcomes Assessment Unit

5/08-4/14 The Zucker Hillside CIDAR Dissecting Heterogeneity of Treatment Response of First episode Schizophrenia
Co-Director, Operations and Clinical Assessment Core

7/10-Present The Zucker Hillside Advanced Center for Intervention and Services Research. Early Phase Schizophrenia: Optimizing Outcomes
Director, Adherence Unit

OTHER ACADEMIC APPOINTMENTS:

4/91-6/04 Albert Einstein College of Medicine
New York, NY
Assistant Professor of Psychiatry and Behavioral Sciences

7/04-6/09 Albert Einstein College of Medicine
New York, NY
Associate Professor of Psychiatry and Behavioral Sciences

7/09-6/11 Albert Einstein College of Medicine
New York, NY
Professor of Psychiatry and Behavioral Sciences

6/11-present Hofstra North Shore-LIJ School of Medicine at Hofstra University
Hempstead, NY
Professor of Psychiatry and of Molecular Medicine

BOARD CERTIFICATION:

1980 Medical License - Pennsylvania
1983 Medical License - New York
1985 Board Certification in Psychiatry

PROFESSIONAL SOCIETY MEMBERSHIP:

American Psychiatric Association
International Early Psychosis Association
American College of Neuropsychopharmacology

AWARDS AND HONORS

1975 Phi Beta Kappa (Vanderbilt)
1979 Outstanding Student in Psychiatry (The University of Tennessee)
2000 Exemplary Psychiatrists Award from the National Alliance for the Mentally Ill

OTHER PROFESSIONAL ACTIVITIES

JOURNAL REVIEWER

Archives of General Psychiatry
American Journal of Psychiatry
Acta Psychiatrica Scandinavica
Schizophrenia Bulletin
Neuropsychopharmacology
Schizophrenia Research
Journal of Substance Abuse
Primary Psychiatry
Clinical Psychology Review
Journal of Clinical Psychiatry
Journal of Mental Health
International Journal of Neuropsychopharmacology
Journal of Clinical Psychopharmacology

GRANT REVIEWER

National Institute of Mental Health (former member of the Neural Basis Of

Psychopathology, Addictions And Sleep Disorders Study Section; ad hoc for other study sections)

Peer Review Committee, Schizophrenia Trials Network (NIMH)

Ontario Mental Health Foundation

The Netherlands Organisation for Health Research and Development

Deutsche Forschungsgemeinschaft (DFG) German Research Foundation

Feinstein Institute for Medical Research

NATIONAL COMMITTEES

DSM-IV Work Group Advisor, Schizophrenia and Other Psychotic Disorders

Principal Contributor, American Psychiatric Association Task Force for the Handbook of Psychiatric Measures

Member, Psychopharmacologic Drugs Advisory Committee, Center For Drug Evaluation And Research, U.S. Food And Drug Administration

Texas Medication Algorithm Project

NATIONAL WORKSHOPS

First Episode Schizophrenia: Preventing Chronicity, Improving Outcomes, National Institute of Mental Health

NEW YORK STATE COMMITTEES

First Episode of Psychosis Augmented Treatment Program (FEAT) Workgroup, New York State Office of Mental Health

HOSPITAL COMMITTEES

Long Island Jewish Research Committee

Quality Assurance Committee, Hillside Research Department

Protocol Review Committee, Hillside Research Department

Scientific Executive Advisory Committee, Feinstein Institute for Medical Research, North Shore-Long Island Jewish Research Institute

RESEARCH

PRINCIPAL INVESTIGATOR (FUNDED STUDIES)

Nocturnal Polysomnography in Obsessive-Compulsive Disorder (Long Island Jewish Faculty Award)
1/90 - 6/92

Double-Blind 12-Week Parallel Comparison of Sertraline and Placebo in Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)
9/91 - 8/93

Double-Blind Parallel Comparison of Sertraline, Imipramine and Placebo in Outpatients with Dysthymia (Pfizer Pharmaceuticals) and Double-Blind Follow-Up Study of Sertraline, Imipramine and Placebo in Outpatients with Dysthymia (Pfizer Pharmaceuticals)
11/91 - 10/93

Double-Blind Parallel Comparison of Sertraline and Desipramine in Outpatients with Concurrent Major Depression and Obsessive Compulsive Disorder (Pfizer Pharmaceuticals) and Double-Blind Follow-Up Study of Sertraline and Desipramine in Outpatients with Concurrent Major Depression and Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)
8/92 - 9/95

Brain Morphology in Obsessive Compulsive Disorder (National Institute of Mental Health)
5/92 - 4/95

Sertraline Treatment Followed by a Double-Blind Comparison of Sertraline and Placebo in the Prevention of Relapse in Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)
3/94 - 9/96

12-Week Double-Blind Comparison of Two Sertraline Dose Regimens in "Nonresponder" Outpatients with Obsessive Compulsive Disorder (Pfizer Pharmaceuticals)
9/94 - 4/96

Fluvoxamine: A Multi-Center, Placebo-Controlled, Randomized, Double-Blind Relapse Prevention Study in the Maintenance Treatment of Outpatients with Obsessive-Compulsive Disorder (Solvay Pharmaceuticals)
1/96 - 12/00

A Prospective, Randomized, International Parallel-Group Comparison of Clozaril/Leponex vs Zyprexa in the Reduction of Suicidality in Patients with Schizophrenia and SchizoAffective Disorder Who Are at Risk for Suicide (Novartis Pharmaceuticals)
4/98 - 4/01

Olanzapine in Attentional Deficits in Schizophrenia (Lilly Research Institute; investigator initiated)
5/98 – 5/03

Preventing Morbidity in First Episode Schizophrenia, Part 1 and Part 2 (competing renewal) (National Institute of Mental Health)
9/98 – 6/11

Long-Acting Risperidone For Patients Who Fail Their First Antipsychotic Treatment Trial (NARSAD)
9/05 – 5/13

2-Way Pagers to Improve Schizophrenia Medication Adherence (National Institute of Mental Health)
5/06 – 3/10

Detecting Which Patients With Schizophrenia Will Improve With Omega 3 Treatment (National Institute of Mental Health)
7/13-6/15

SITE PRINCIPAL INVESTIGATOR

Decision Support for Smoking Cessation in Young Adults with Severe Mental Illness (National Cancer Institute)
9/12-ongoing

DIRECTOR

ACISR: Early Phase Psychosis: Informing Treatment Decisions Adherence Unit
7/10-ongoing

CO-DIRECTOR

ACISR: Early Phase Schizophrenia-Optomizing Outcomes Adherence Unit
9/05- 6/10

CIDAR: Dissecting Heterogeneity of Treatment Response of First episode Schizophrenia Operations and Clinical Assessment Core (National Institute of Mental Health)
5/08 – 4/13

CO-PRINCIPAL INVESTIGATOR

Prospective Study of First Episode Schizophrenia (National Institute of Mental Health)
8/87 - 6/96

CO-INVESTIGATOR

Course of Illness in Schizophrenia: Optomizing Outcomes Schizophrenia (National Institute of Mental Health)
2/00 – 1/06

Longitudinal Neuroimaging of First Episode Schizophrenia (National Institute of Mental Health)
7/00 - 6/05

Recovery After Initial Schizophrenia Episode (National Institute of Mental Health)
7/09-ongoing

Improving Substance Use and Clinical Outcomes in Heavy Cannabis Users (National Institute of Health)
7/10-6/13

Improving Quality And Reducing Cost In Schizophrenia Care With New Technologies And New Personnel (CMMS/CMMI)
7/12-ongoing

A Cluster Randomized, Multi-center, Parallel-group, Rater-blind Study Comparing Treatment with Aripiprazole Once Monthly and Treatment as Usual on Effectiveness in First Episode and Early Phase Illness in Schizophrenia (Investigator Initiated, supported by Otsuka)
8/14-ongoing

CONSULTANT

Educational Material for Geriatric Psychopharmacology: Phase I (Small Business Innovation Research Program)
7/96 - 12/96

Educational Material for Geriatric Psychopharmacology: Phase II (Small Business Innovation Research Program)
11/00 – 4/05

A New Scale to Assess Psychopathology in Schizophrenia (NARSAD)
6/01 – 11/05

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Robinson, DG, Schooler, NR, John, M, Correll, CU, Marcy, P, Addington, J, Brunette, MF, Estroff, SE, Mueser, KT, Penn, D, Robinson, J, Rosenheck, RA, Severe, J,

Goldstein, A, Azrin, S, Heinssen, R, Kane, JM: Prescription practices in the treatment of first-episode schizophrenia spectrum disorders: data from the national RAISE-ETP study. Am. J. Psychiatry 172: 237–248, 2015.

Robinson, DG, Schooler, NR, Kane, JM: Response to Saraga. Am. J. Psychiatry 172: 588, 2015.

BOOKS, CHAPTERS IN BOOKS AND REVIEW ARTICLES

Robinson D, Jody D, Lieberman, J: "Provocative Tests with Methylphenidate in Schizophrenia and Schizophrenia Spectrum Disorders" in Greenhill L, Osman B (eds) Ritalin: Theory and Patient Management, Mary Ann Liebert, New York, NY, 1991.

Flaum M, Amador X, Gorman J, Bracha HS, Edell W, McGlashan T, Pandurangi A, Kendler K, Robinson D, Lieberman J, Ontiveros A, Tohen M, McGorry P, Tyrrell G, Arndt S, Andreasen N: "DSM-IV Field Trial for Schizophrenia and Other Psychotic Disorders" in Widiger TA, Frances AJ, Pincus HA, Ross R, First MB, Davis W, Kline M (eds) DSM-IV Sourcebook Volume 4, American Psychiatric Association, Washington DC, 1998.

Goldman RS, Robinson D, Grube B, Hanks R, Putnam K, Walder D, Kane J: "General Psychiatric Symptom Measures" in First MB (ed) Handbook of Psychiatric Measures and Outcome, American Psychiatric Press, Washington, D.C, 2000.

Robinson D: "Treatment of Schizophrenia at the First Episode" in Harvey P, Sharma T (eds) The Early Course of Schizophrenia: Schizophrenia in the Premorbid Period, Oxford University Press, Oxford, UK, 2006.

Delman HM, Robinson DG, Kimmelblatt CA, McCormack J: "General Psychiatric Symptom Measures" in Rush AJ, First MB, Blacker D (eds) Handbook of Psychiatric Measures Second Edition, American Psychiatric Publishing, Washington, DC, 2008.

Piper Suzanne Meyer-Kalos, Ph.D., LP

Business:
College of Continuing Education
University of Minnesota
20 Ruttan Hall
1994 Buford Ave
St Paul, MN 55108
(612) 625-5566 (wk)
919-697-6446 (cell)
Email: psmeyer@umn.edu

Education and Licensure

Minnesota Licensed Psychologist (#LP5617) — **April 30, 2013**

North Carolina Licensed Psychologist and Health Services Provider Psychologist (#3277) — **October 2, 2006**

Postdoctoral Fellowship — **2003- 2005**
National Research Service Award (NRSA) Fellowship, Mental Health and Substance Abuse Systems and Services, Cecil G. Sheps Center for Health Services Research, University of North Carolina
Chapel Hill, North Carolina

Doctorate, Clinical Rehabilitation Psychology — **1997- 2003**
Purdue University School of Science, Indianapolis, IN
Dissertation: The cognitive factor of the PANSS: A confirmatory factor analysis and related cognitive correlates

Master of Science, Clinical Rehabilitation Psychology — **1999**
Purdue University School of Science, Indianapolis, IN
Master's Thesis: The impact of atypical antipsychotics on vocational outcomes

Bachelor of Arts, Psychology, Minor: Sociology — **1995**
DePauw University, Greencastle, IN

Professional Appointments/Employment

Director — 2013 - current
Minnesota Center for Chemical and Mental Health (MNCAMH), St. Paul, MN
Director of a statewide center of excellence to provide training, research, and resources for emerging and existing practitioners and to build and sustain excellence in the delivery of mental health services. Coordinating and conducting mental health and addictions research and workforce

development, acquiring external support, connecting the Center to the community providers, establishing center infrastructure, and supervising graduate research assistants.

Research Assistant Professor 2005 - 2013

UNC-CH Department of Psychology, Chapel Hill, NC

Research coordinator for a clinical psychology lab focused on psychosocial treatment for schizophrenia and the assessment of social cognition in schizophrenia. Supervised undergraduate lab staff, provided clinical supervision for research projects, participated in development of grants, and development of psychosocial curriculum. Developed community alliances with county/state agencies to recruit for research studies.

Research Projects:

- Recovery After Initial Schizophrenia Episode (RAISE). Co-developed an individual therapy for people with first episode psychosis, and conducted training, ongoing clinical supervision, and fidelity evaluations for 13 national sites.
- The Farm at Penny Lane. Coordinating the development of a garden/farm program for persons with mental health disorders. Developing program evaluation measures to evaluate nutrition, weight, mental health, and activity level.
- Positive Living. Adapted a positive psychology treatment for people with schizophrenia and conducted pilot studies with persons with schizophrenia. Utilized pilot research in recent grant application.
- Social Cognition and Interaction Training (SCIT). Project coordinator for a treatment aimed at improving social cognition for persons with schizophrenia.
- An investigation of Group Cognitive Behavioral Therapy (CBT) compared to Supportive Therapy for Auditory Hallucinations. Project coordinator and group facilitator.

Postdoctoral Fellowship, Cecil G Sheps Center, University of North Carolina 2003- 2005
Chapel Hill, North Carolina

Research Assistant, Mental Illness and Research Education and 2002 - 2003
Clinical Center (MIRECC), Veteran's Administration,
Baltimore, Maryland

Intensive Case Manager, CREOKS Mental Health Services, 1995 - 1997
Oklahoma State Certified Case Manager for Creek County.
Sapulpa, OK

Clinical Experience

Postdoctoral Fellowship, Department of Psychiatry, 2003 –2005
STEP Clinic, University of North Carolina, Chapel Hill, NC

- Provided manualized individual and therapy for adults with serious mental illness using Illness Management and Recovery and Graduated Recovery Intervention Program.

Clinical Psychology Intern, Serious Mental Illness Track — 2002 - 2003
University of Maryland School of Medicine,
Baltimore, MD (APA approved program)

- Provided individual therapy and case management in an urban community mental health center. Taught psychoeducational groups and social skills training groups. Participated in specialty rotations including sex offender's treatment clinic and mental health and substance abuse treatment program for federal pretrial and probation.

Practicum, LaRue Carter Hospital, — 2000 - 2001
Indianapolis, IN

- Adolescent Inpatient Unit. Therapist for adolescents on an inpatient unit with developmental disabilities, learning disabilities, medical disorders, and behavioral problems.

Practicum, Indiana Women's Prison, — 2000
Indianapolis, IN

- Special Needs Unit and Indiana Women's Intake Unit. Provided group therapy on the Special Needs Unit. Conducted psychological evaluations including tests of intelligence, personality, and neuropsychology.

Practicum, Counseling and Psychological Services, IUPUI — 2000
Indianapolis, IN

- University counseling center. Provided individual and couples counseling including cognitive-behavioral therapy for persons aged 18 to 45.

Practicum, Veterans Administration — 1998 - 1999
Indianapolis, IN

- Provided group and individual psychotherapy for individuals with psychiatric disabilities. Population was primarily those with serious mental illness. Assisted in research projects.

Practicum, Veterans Administration, NIMH Research Project, — 1998
Indianapolis, IN

- Conduct assessment interviews for elderly depressed women, including SCID,

CES-D, Mini Mental Status, Coping, and Network Transactions.

Teaching and Training Experience

Instructor, University of Haifa, Israel, Social Cognition and Interaction Training (SCIT) and Positive Psychotherapy for people with schizophrenia. — September 2011

Consultation and Training, State of Missouri, Illness Management and Recovery for an inpatient forensic unit. — 2011 - 2013

Consultation and Training, University of Medicine and Dentistry of New Jersey, for the state of New Jersey, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies for IMR — 2007 – 2013

Consultation and Training, Minnesota Department of Human Services, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies For IMR, IMR Clinical Competency Scales — 2006 – 2013

Consultation and Training, North Carolina Evidence-Based Practice Center, Wellness Management and Recovery — 2004 – 2007

Recitation Instructor, Introductory Psychology, IUPUI, Indianapolis, IN — 2002 - 2002

Awards

Clinical Rehabilitation Psychology Outstanding Master's Student Award — 1999
IUPUI, Indianapolis, IN

Rehabilitation Services Administration Fellowship — 1997 -1998
IUPUI, Indianapolis, IN

Outstanding Service Award — 1996
CREOKS Mental Health, Sapulpa, OK

Professional Organizations

American Psychological Association — 2008-2009
Association of Behavioral and Cognitive Therapy — 2007-current

Publications

Parks, A., Kleiman, E. M., Kashdan, T. B., Hausmann, L. R. M., **Meyer, P. S.**, Day, A. M., Spillane, N. S., & Kahler, C. W. (in press). Positive Psychotherapeutic and Behavioral Interventions. In Jeste and Palmer, (eds.) Positive Psychiatry, A Clinical Handbook. American Psychiatric Press.

Buck, B., Ludwig, K., **Meyer, P. S.**, Penn, D. (2014). The use of narrative sampling in the assessment of social cognition: The Narrative of Emotions Task (NET). Psychiatry Research, 217(3), 233-239.

Meyer, P. S., Johnson, D., Parks, A., Iwanski, C., Penn, D. (2012). Positive living: A pilot study of group positive psychotherapy for people with schizophrenia. Journal of Positive Psychology, 7(3), 239-248.

Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2011). Loving-kindness meditation for schizophrenia. Schizophrenia Research, 129(2/3), 137-140.

Meyer, P. S. & Mueser, K. T. (2011). Resiliency in persons with severe mental illness. In Southwick, Litz, Charney, Friedman, (eds.) Resilience and Mental Health: Responding to challenges across the lifespan. Cambridge University Press.

Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D. J., **Meyer, P. S.**, Penn, D. L. (2010). Upward spirals of positive emotions counter downward spirals of negativity: Insights from the broaden-and-build theory and affective neuroscience on the treatment of emotion dysfunctions and deficits in psychopathology. Clinical Psychology Review, 30(7), 849-864.

Meyer, P. S., Mueser, K. T., Gingerich, S. (2010). A guide for the implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, A. and Springer, D. (eds.) Psychosocial treatment for schizophrenia. John Wiley & Sons.

Penn, D. L., Keefe, R. S., Davis, S. M., **Meyer, P. S.**, Perkins, D. O., Losardo, D., Lieberman, J. A., (2009). The effects of antipsychotic medications on emotion perception in patients with chronic schizophrenia in the CATIE trial. Schizophrenia Research, 115 (1), 17-23.

Penn, D. L., **Meyer, P. S.**, Evans, E., Cai, K., Wirth, R. J., Burchinal, M. (2009). A randomized controlled trial of group cognitive behavior therapy versus enhanced supportive therapy for auditory hallucinations. Schizophrenia Research, 109 (1-3), 52-59.

Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2009). Loving-kindness meditation to enhance the psychological recovery of individuals with persistent negative symptoms of schizophrenia: A case study. Journal of Clinical Psychology, 65(5), 499-509.

Johnson, D. P., Penn, D. L., Bauer, D. J., **Meyer, P.**, Evans, E. (2008). Predictors of the therapeutic alliance in group therapy for individuals with treatment-resistant auditory hallucinations. British Journal of Clinical Psychology 47(2), 171-183.

Morrissey, J. P., **Meyer, P. S.**, Cuddeback, G. (2007). Extending ACT to criminal justice settings: Origins, evidence, and future directions. Community Mental Health Journal 43(5), 527-544.

Meyer, P.S. & Morrissey, J. P. (2007). Assertive community treatment, intensive case mangement, and the paradox of rural mental health services. Psychiatric Serivces 58(1), 121-127.

Cuddeback, G., Morrissey, J. P., **Meyer, P. S.** (2006). How many assertive community treatment teams do we need? Psychiatric Services 57(12), 1803-1806.

Mueser, K. T., **Meyer, P. S.**, Penn, D. L., Clancy, R., Clancy, D. M., Salyers, M. P. (2006). The Illness Management and Recovery program: Rationale, development, and preliminary findings. Schizophrenia Bulletin, 32, S32-S43.

Evans, J. D., Bond, G. R., **Meyer, P. S.**, Kim, H. W., Lysaker, P. H., Gibson, P. J., Tunis, S. (2004). Cognitive and clinical predictors of success in vocational rehabilitation in schizophrenia. Schizophrenia Research, 70(2-3), 331-342.

Bond, G. R., Kim, H. W., **Meyer, P. S.**, Gibson, P. J., Tunis, S., Evans, J. D., Lysaker, P., McCoy, M. L., Dincin, J., Xie, H. (2004). Response to Vocational Rehabilitation During Treatment with First- or Second-Generation Antipsychotics. Psychiatric Services, 55, 59-66.

Salyers, M. P., Evans, L. J., Bond, G. R., **Meyer, P. S.** (2004). Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people with severe mental illness: Clinician perspectives. Community Mental Health Journal, 40, 17-31.

Meyer, P. S., Bond, G. R., Tunis, S. L., McCoy, M. L. (2002). Comparison between atypical and traditional antipsychotics in work status for clients in a psychiatric rehabilitation program. Journal of Clinical Psychiatry, 63, 108-116.

Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., Clements, C.A. & Marks, K.A. (2001) Psychosocial correlates of childhood sexual trauma in schizophrenia. Psychiatric Services, *52*, 1485-1488.

Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., & Marks, K.A. (2001). Neurocognitive correlates of self reported sexual abuse in schizophrenia spectrum disorders. Annals of Clinical Psychiatry, *13*, 89-92.

Bond, G.R. & **Meyer, P. S.** (1999). The role of medications in the employment of people with schizophrenia. Journal of Rehabilitation, 65(4), 9-16.

Presentations

Meyer, P.S., (July 2011). Positive Living: A pilot study of group positive psychotherapy for people with schizophrenia. Symposium at Second World Congress on Positive Psychology.

Meyer, P.S., Johnson, D., Penn, D. L. (November 2009). Positive living: An adaptation of group positive psychotherapy for people with psychotic disorders. Symposium at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D.L., Roberts, D., Koren, D. (November 2008). The relationship between metacognition, social cognition, and social functioning in schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Johnson, D., Penn, D., **Meyer, P.,** Fredrickson, B., Kring, A., Brantley, M. (November 2008). Loving kindness group meditation for the negative symptoms of schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D.L., Evans, E., Cai, K., Burchinal, M. (November 2007) A randomized controlled trial of group CBT and supportive therapy for auditory hallucinations. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D., Mueser, K., Waldheter, E. (April 2005). A pilot study of illness management and recovery for persons with psychotic disorders. Poster presentation at the International Congress on Schizophrenia Research.

Meyer, P.S. & Morrissey, J. P. (June 2004). Overlooked Obstacles in Disseminating Assertive Community Treatment in Rural Settings. Poster presentation at the NIMH Trainees Research Conference.

Meyer, P.S., Gearon, J., Bellack, A., & Brown, C. (March 2003). The Relationship Between Traumatic Life Events and Posttraumatic Stress Disorder in Substance Abusing Women with Schizophrenia. Poster presentation at the International Congress on Schizophrenia Research.

Bond, G.R., **Meyer, P.S.,** Kim, H., Marks, K. & Tunis, S.L. (February 2001). The promise of new antipsychotics and psychiatric rehabilitation for improving work outcomes: Why haven't state mental health systems embraced best practices? Oral presentation at the NASMHPD Eleventh Annual Conference on State Mental Health Agency Services Research, Program Evaluation.

Kim, H.W., Tunis, S.L., Bond, G.R., Marks, K.A., & **Meyer, P.S.** (2001). Psychiatric Symptoms & Adverse Events Commonly Reported During Antipsychotic Treatment for Individuals with Schizophrenia Participating in Psychiatric Rehabilitation Programs. Poster presentation at the Annual Convention of the American Psychiatric Association.

Lysaker, P.H., Evans, J.D., Kim, H.W., Marks, K.A., **Meyer, P.S.,** Tunis. S.L., & Bond, G.R. (2001). Symptoms and work performance in schizophrenia. Poster presentation at the International Congress of Schizophrenia.

Meyer, P. S., Kim, H. W., Bond, G. R., Tunis, S., McCoy, M., & Dincin, J. (October, 2000). Impact of Antipsychotic Medications on Vocational Outcomes for Persons with

Schizophrenia. Oral presentation at the MRI/UPENN Rehabilitation and Research Training Center 4th Biennial Research Seminar on Work.

Meyer, P., Bond, G. R., Herbeck, D., McCoy, T., and Rowan, D. (May 1999). The promise of newer antipsychotics: Implications for social and vocational outcomes. Workshop presented at International Association of Psychosocial Rehabilitation Services. Minneapolis, MN.

Meyer, P. S., Bond, G. R., McCoy, T., Herbeck, D., Rowan, D., and Tunis, S. (April, 1999). The influence of atypical antipsychotics on work outcomes. Poster presented at the International Congress on Schizophrenia Research, Santa Fe, NM.

Unpublished Manuscripts

Meyer, P. S. and Morrissey, J. P. (2004). Assertive community treatment in North Carolina: Implementation status and training needs. Report submitted to North Carolina Science to Service, Research Triangle Park, NC.

Bond, G., **Meyer, P.**, Rollins, A., McCoy, M., Herbeck, D., and Rowan, D. (1998). The impact of atypical antipsychotics on vocational outcomes in a psychiatric rehabilitation agency. Reported submitted to Eli Lilly, Indianapolis, IN.

References Available upon Request

David W. Lynde, MSW, LICSW
Mental Health Services Consultant & Trainer

Education

- Boston University, Masters in Social Work, 1992
- University of New Hampshire, B.A. in Social Work, 1982

Employment

David W Lynde Independent Consultant and Trainer Implementing Evidence Based Mental Health Practices, 2004 - Present

- Consultant and Trainer to NH Bureau of Mental Health Services for Dartmouth Hitchcock Medical Center regarding implementation and sustaining of Mental Health Evidence Based Practices (Supported Employment, Assertive Community Treatment, and Illness Management & Recovery)
- Consultant to Marc Gould Associates regarding the development and implementation of the Pathways to Careers employment model for people with mental illness
- Developer, Trainer and Consultant regarding NIMH RAISE project for Supported Employment and Supported Education for national first episode psychosis project
- Previous Deputy Project Director for Dissemination for the National Registry for Evidence-based Practices and Programs (NREPP) for the Substance Abuse and Mental Health Services Administration (SAMHSA) (Developmental Services Group, Inc.)
- Expert consultant to United States Department of Justice regarding Supported Employment implementation for State of Georgia Olmstead Settlement Agreement
- Expert consultant to Arizona Department of Health Services vis-à-vis National Association of State Mental Health Program Directors regarding implementation of four EBPs
- Co-Director, Atlas Research & Easter Seals National Training Program for National Veterans Administration" Homeless Veteran Supported Employment Program"
- Consultant and Trainer for Department of Veterans Affairs regarding national implementation of Supported Employment in Compensated Work Therapy program
- Evidence Based Practices implementation consultation and technical assistance to multiple state, county, municipal and national mental health systems regarding implementation of Evidence Based Mental Health Practices

Dartmouth Psychiatric Research Center, 2000-2013

- Co-Director, Dartmouth Evidence Based Practices (EBP) Center for Implementing Evidence-Based Mental Health Practices
- Consultant and Trainer regarding Organizational Change and Implementation of Evidence-Based Practices for State, County and Municipal Mental Health Systems
- Developer, Technical Assistant and Consultant regarding five Evidence Based Practices "toolkits" and implementation process for National Implementing Evidence Based Practices Project from SAMHSA

- Co-developer of the State Health Authority Yardstick (SHAY) to measure and guide State and System level implementation actions for evidence-based mental health services.
- National Core Staff, Johnson & Johnson – Dartmouth Community Mental Health Program for multi-state implementation of Supported Employment Services
- Director of Consultation and Training services regarding implementation of EBPs for all Community Mental Health Centers in New Hampshire and NH Bureau of Behavioral Health
- 2005-2008 Information technology workgroup leader and leadership committee member, Governor's Commission on the transformation of services for mental illness in New Hampshire
- Co-Chair and Quality Workgroup Leader for New Hampshire Governor's Commission on the transformation of mental health services

University of New Hampshire, Durham, NH

- Adjunct Faculty, Social Work Department, 1994-2005
- University of New Hampshire Social Work Department Advisory Board, 1992-2010

Boston University School of Social Work

- Adjunct Faculty, Graduate Social Work Program 2004-2005

Center for Life Management, Community Mental Health Center, Salem, New Hampshire

- Director of Community Support Programs, 1997-2000
- Director of Clinical Services, Community Support Programs, 1995-1997
- State Psychiatric Hospital Liaison 1990-1995
- Director of Outpatient Support Services, 1993-1995
- Clinician, Community Support Services, 1990-1993
- Case Manager, Community Support Services, 1987-1990
- Residential Manager, Adolescent Treatment Facility, 1985-1987

Professional Licensure

- Licensed Independent Clinical Social Worker, State of New Hampshire, 1994-Present (current status inactive)

KEY ADMINISTRATIVE PERSONNEL

NH Department of Health and Human Services

Contractor Name: Mary Hitchcock Memorial Hospital

Name of Contract: Trainer for First Episode Psychosis (FEP) Treatment Services RFP-2017-DBH-05-Firste Amendment #1

BUDGET PERIOD:	SFY 18 (July 1, 2017-June 30, 2018)			
NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Alan I. Green	Executive Director	$0.00	0%	$0.00
Susan Gingerich, MSW	Director & Family Clinician Trainer and Consultant	$12,678.00	100%	$12,678.00
Delbert Robinson, MD	Prescriber Trainer and Consultant	$20,308.70	100%	$20,308.70
Piper Meyer-Kalos, PhD	Individual Resiliency Trainer (IRT) and Consultant	$7,650.00	100%	$7,650.00
David Lynde, MSW	Supported Employment and Education Trainer (SEE) and Consultant	$6,050.00	100%	$6,050.00
			Consultant Subtotal	$46,686.70
Erika G. Pierce	Program Coordinator/Admin. Support	$25.00/hr. + fringe	100%	$0.00
			Admin. Support subtotal	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$46,686.70**

BUDGET PERIOD:	SFY 19 (July 1, 2018-September 30, 2018)			
NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Alan I. Green	Executive Director	$0	0%	$0.00
Susan Gingerich, MSW	and Consultant	$5,178.00	100%	$5,178.00
Delbert Robinson, MD	Prescriber Trainer and Consultant	$750.00	100%	$750.00
Piper Meyer-Kalos, PhD	and Consultant	$500.00	100%	$1,500.00
David Lynde, MSW	Education Trainer (SEE) and	$750.00	100%	$1,000.00
			Consultant Subtotal	$8,428.00
Erika G. Pierce	Program Coordinator/Admin. Support	$25.00/hr. + fringe	100%	$2,193.75
			Admin. Support subtotal	$2,193.75
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$10,621.75**

BUDGET PERIOD:	SFY 20 (October 1, 2018-June 30, 2019)			
NAME	JOB TITLE	SALARY	PERCENT PAID FROM THIS CONTRACT	AMOUNT PAID FROM THIS CONTRACT
Alan I. Green	Executive Director	$0	0%	$0.00
Susan Gingerich, MSW	Director & Family Clinician Trainer and Consultant	$22,100	100%	$22,100.00
Delbert Robinson, MD	Prescriber Trainer and Consultant	$12,800	100%	$12,800.00
Piper Meyer-Kalos, PhD	Individual Resiliency Trainer (IRT) and Consultant	$32,750	100%	$32,750.00
David Lynde, MSW	Supported Employment and Education Trainer (SEE) and Consultant	$15,050	100%	$15,050.00
			Consultant Subtotal	$82,700.00
Erika G. Pierce	Program Coordinator/Admin. Support	$25.00/hr. + fringe	100%	$0.00
			Admin. Support subtotal	$0.00
TOTAL SALARIES (Not to exceed Total/Salary Wages, Line Item 1 of Budget request)				**$82,700.00**

Item #24 G&C approved 9-27-2017

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

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

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August 28, 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 of Behavioral Health, Bureau of Mental Health Services, to enter into an agreement with Mary Hitchcock Memorial Hospital, Vendor #177160, One Medical Center Drive, Lebanon, NH 03756, in an amount not to exceed $197,164.41, to provide a training program for First Episode Psychosis, effective upon Governor and Executive Council approval, through September 30, 2018. 100% Federal Funds.

Funds are available in the following accounts 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.

05-95-092-922010-4120-102 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SVS, HHS: DIVISION OF PUBLIC HEALTH, HHS: DIVISION OF BEHAVIORAL HEALTH, MENTAL HEALTH BLOCK GRANT

Fiscal Year	Class/Account	Class Title	Job Number	Total Amount
SFY 2018	102/500731	Contracts for Prog Svc	92224120	$161,820.86
SFY 2019	102/500731	Contracts for Prog Svc	92224120	$35,343.55
			Total	**$197,164.41**

EXPLANATION

The purpose of this agreement is for the provision of a training program to the Community Mental Health Center System for First Episode Psychosis (FEP) patients. First Episode Psychosis is a comprehensive approach to treatment for individuals with first or early stage manifestation of a psychotic disorder. Early intervention services for First Episode Psychosis can improve symptoms and restore functioning in a manner superior to standard care services. First Episode Psychosis treatment services include Coordinated Specialty Care (CSC), delivered by a team of several professionals with different levels and areas of expertise.

Each year approximately 100,000 young people in the United States experience a first episode of mental illness. Long delays between the onset of mental illness and effective treatment are typical. A 2015 study of more than four-hundred (400) people in the United States with early symptoms found

that half experienced symptoms for nearly eighteen (18) months before beginning treatment. This is almost six times the World Health Organization's quality standard of a maximum twelve (12) weeks. Research shows that integrated coordinated specialty care effectively reduces symptoms and improves functioning.

Funds in this agreement will be used to continue a statewide training program, beginning with one Community Mental Health Center, using the NAVIGATE model, a team-based approach to specialized early intervention in mental illness. This treatment model emphasizes prompt detection, acute care during periods of crisis, and services to lead youth and young adults who are experiencing symptoms of mental illness for the first time, toward a continuation of healthy functioning.

Findings reported by the National Institute for Mental Health show that over two (2) years clients at the NAVIGATE clinics stayed in treatment longer; experienced greater improvement in their symptoms, in their interpersonal relationships, and in their quality of life; and were more involved in work or school compared to clients at typical-care sites.

Mary Hitchcock Memorial Hospital was selected for this project through a competitive bid process. A Request For Proposals for a trainer for First Episode Psychosis (FEP) Treatment Services was posted on The Department of Health and Human Services' web site from November 30, 2016 through January 30, 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 proposal. The Bid Summary is attached.

As referenced in the Request For Proposals and in Exhibit C-1 of this contract, this Agreement has the option to extend 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.

Area served: Statewide.

Source of Funds: 100% Federal Funds. Catalog of Federal Domestic Assistance (CFDA) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-17.

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

Trainer for First Episode Psychosis (FEP) Treatment Services
RFP Name

RFP-2017-DBH-05-FIRSTE
RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Dartmouh-Hitchcock		180	140
2. 0		180	0
3. 0		180	0
4. 0		180	0

Reviewer Names

1. Brian Huckins, NAMI Child & Family Liaison, Volunteer, Tech
2. Effie Malley, Mbr NH Mental Health Planning Advisry Council, Volunteer
3. Adele Gallant - Administrator, Bureau Children's Behavioral Health
4. Harry Cunningham, Training Director; Manchester Mental Health, Volunteer
5. Ann Driscoll, Administrator III, Ofc of Improvement & Integrity. Cost Team
6. Tanja Milic, DBH, Business Administrator II, Cost Team

FORM NUMBER P-37 (version 5/8/15)

Subject: Trainer for First Episode Psychosis (FEP) Treatment Services/RFP-2017-DBH-05-FIRSTE

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 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 One Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number 603-650-6404	1.6 Account Number 05-95-092-922010-4120-102	1.7 Completion Date September 30, 2018	1.8 Price Limitation $197,164.41
1.9 Contracting Officer for State Agency Jonathan V. Gallo, Esq. Interim Director of Contracts and Procurement		1.10 State Agency Telephone Number 603-271-9246	
1.11 Contractor Signature [signature]		1.12 Name and Title of Contractor Signatory Daniel P. Jantzen, Chief Financial Officer	
1.13 Acknowledgement: State of New Hampshire, County of Grafton On [illegible], 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~~ [signature] [Seal: FAITH E. JOHNSTON, MY COMMISSION EXPIRES SEPT. 21, 2021, NOTARY PUBLIC, NEW HAMPSHIRE]			
1.13.2 Name and Title of Notary or Justice of the Peace			
1.14 State Agency Signature [signature] Date: 8/30/17		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: [signature], Attorney On: 9/7/17			
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 [signature]
Date 8/21/17

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 [initials]
Date 8/21/17

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 [signature]
Date 8/21/17

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will 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 coordinate and establish a Coordinated Specialty Care (CSC) team for the Nashua Community Mental Health Center (CMHC).

2.2. The Contractor shall provide training to the Nashua CMHC on First Episode Psychosis Treatment Services used to treat individuals ages fifteen (15) to thirty-five (35) who present with symptoms of a psychotic disorder and meet State eligibility criteria for either a:

2.2.1. Serious Emotional Disturbance (SED) or Serious Emotional Disturbance with Interagency Involvement (SED-IA) as determined through the use of the Child and Adolescent Needs and Strengths (CANS) assessment; or

2.2.2. Serious Mental Illness (SMI) as determined through the use of the Adult Needs and Strengths Assessment (ANSA).

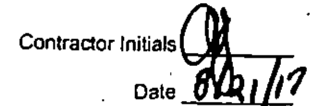
2.3. The Contractor shall provide a training program to ensure the Nashua Community Health Center can implement First Episode Psychosis (FEP) treatment services and continue those services beyond the training period, which shall include, but not be limited to:

2.3.1. Initial Assessments.

2.3.2. Clinical and Support Skills.

2.3.3. Coordination of FEP treatment.

2.4. The Contractor shall ensure that all materials for trainings shall clearly indicate that no Protected Health Information (PHI), Personally Identifiable Information (PII), or other confidential information shall be revealed by trainees during training sessions or during any consultations with Contractor or Sub-Contractors.



2.5. The Contractor shall train Nashua CMHC staff in the FEP NAVIGATE Model, which includes but is not limited to:

2.5.1. Training FEP team members in fundamental information about FEP.

2.5.2. Training on how to use joint decision-making with clients and natural supports.

2.5.3. Specialty training for specific staff roles, which includes but is not limited to:

2.5.3.1. Motivational interviewing strategies.

2.5.3.2. Cognitive-behavioral strategies.

2.5.3.3. Strategies for involving family members and other supporters.

2.5.4. Clinical and support skills that will enable all team members to:

2.5.4.1. Use shared decision-mailing with clients, family members and other supporters.

2.5.4.2. Identify characteristics of individuals with first episode or early psychosis.

2.5.4.3. Describe how clients with first episode schizophrenia differ from those who experience multi-episode schizophrenia.

2.5.4.4. Identify the key needs of individuals with first or early psychosis.

2.5.4.5. Contribute to the weekly FEP NAVIGATE team meetings.

2.5.4.6. Identify key outcomes that can be improved by clients who participate in FEP treatment.

2.6. The Contractor shall ensure the Nashua CMHC FEP team includes, but are not limited to:

2.6.1. A Program Director who is trained to:

2.6.1.1. Educate the community on FEP in order to increase early recognition of psychosis.

2.6.1.2. Recruit individuals who have begun to experience psychosis.

2.6.1.3. Lead the FEP team.

2.6.2. A Family Education (FE) Clinician (who may also be the Program Director) who is trained to:

2.6.2.1. Assist natural supports in learning:

2.6.2.1.1. General information about psychosis

2.6.2.1.2. How to manage psychosis.

2.6.2.1.3. How to support each other and build 'family resiliency.'

2.6.2.2. Conduct outreach and recruitment to community agencies.

2.6.2.3. Evaluate potential clients for the NAVIGATE program.

2.6.2.4. Use engagement strategies to involve clients in treatment.

2.6.2.5. Conduct weekly team meetings and collaborative treatment planning meetings.

2.6.2.6. Identify common reactions in family members of individuals with FEP.

2.6.2.7. Use engagement strategies to involve natural supports in treatment.

2.6.2.8. Conduct illness education sessions with natural supports of persons with early psychosis.

2.6.2.9. Identify and teach coping strategies for natural supports in order to assist them in responding to clients in a supportive manner.

2.6.2.10. Teach communication and problem solving skills to the client's natural supports.

2.6.2.11. Assist natural supports to identify and strengthen their own resiliency.

2.6.3. A Prescriber (psychiatrist, nurse practitioner or physician's assistant) who is trained to:

2.6.3.1. Use low doses of medications to treat FEP.

2.6.3.2. Understand special issues of relevance to individuals experiencing FEP, which may include but is not limited to:

2.6.3.2.1. Avoiding authoritarian approaches.

2.6.3.2.2. Using strategies for accommodating client ambivalence

2.6.3.3. Identify early signs that an individual sis developing symptom of psychosis.

2.6.3.4. Describe the differences between recommended medication sequences for first episode and multi-episode schizophrenia.

2.6.3.5. Integrate the use of the Client Self-Questionnaire in client appointments.

2.6.3.6. Use strategies for joint decision-making as it applies to prescribing medication for clients.

2.6.3.7. Use strategies for retaining early phase psychosis clients in treatment.

2.6.3.8. Describe outcome differences between RAISE-ETP (FEP NAVIGATE) treatment programs and standard care for early phase psychosis.

2.6.4. An Individual Resiliency Trainer (IRT) who is trained to:

2.6.4.1. Assist individuals identify and work towards their goals

2.6.4.2. Teach individuals strategies and skills to build resiliency in coping with psychosis while staying on track with their lives.

2.6.4.3. Focus on individual strengths and resiliency to assist with personal recovery goal setting.

2.6.4.4. Identify strategies that individuals can use to cope with psychosis.

2.6.4.5. Educate clients about the negative effects of substance use on psychosis and provide a message of hope and optimism for overcoming substance use problems.

2.6.4.6. Assist clients with processing the experience of having a first episode of psychosis.

2.6.4.7. Use cognitive behavioral therapy techniques such as cognitive restructuring.

2.6.4.8. Use psychoeducational techniques to teach clients about psychosis and recover.

2.6.5. A Supported Employment And Education (SEE) Specialist) trained to:

2.6.5.1. Assist individuals identify their educational and/or employment goals.

2.6.5.2. Assist individuals with achieving their educational and/or employment goals.

2.6.5.3. Identify key principles for supporting individuals in pursuing evaluation and employment goals.

2.6.5.4. Collaborative complete a Career Inventory.

2.6.5.5. Use strategies to assist individuals with identifying specific career goals.

2.6.5.6. Provide rapid job search and rapid school search to clients, based on client preference.

2.6.5.7. Develop job and school opportunities in the community for FEP clients.

2.6.5.8. Provide follow along supports for clients who have obtained a job or enrolled in school.

2.6.6. A specified FEP team member or a separate case manager trained to:

2.6.6.1. Trained to assist individuals obtain needed services through community resources, such as housing and transportation.

2.6.7. A Peer Support who is either a specified FEP team member or and individual from an outside peer specialist program who is trained to:

2.6.7.1. Assist clients by sharing experiences of recovery.

2.6.7.2. Assist clients to get back on track with their lives, which may include, but is not limited to:

2.6.7.2.1. Working.

2.6.7.2.2. Attending school.

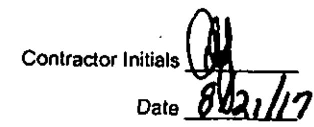
2.6.7.2.3. Fostering positive relationships.

2.6.7.2.4. Developing a strong support system.

2.7. The Contractor shall implement FEP NAVIGATE Training in four phases, as approved by the Department, which include:

2.7.1. Phase 1- Refresher and Preparation to continue implementing the FEP team. The Contractor shall complete an assessment of and provide support for the Nashua CMHC to ensure the agency is prepared to continue implementing the NAVIGATE program. Phase 1 activities include, but are not limited to:

2.7.1.1. Telephone consultations with the Nashua CMHC in order to assess readiness for receiving training. The Contractor shall ensure consultations are conducted in the presence of the CMHC administrative and



clinical leadership and topics include, but are not limited to:

2.7.1.1.1. Discussion of the facility and its services, including but not limited to, any current early psychosis efforts; characteristics of the current population served; and plans for continuing the implementation of FEP NAVIGATE.

2.7.1.1.2. Overview of Phase 2 and Phase 3 format requirements.

2.7.1.1.3. Identification and formal 'buy-in' of local FEP leadership team and stakeholders.

2.7.1.1.4. Identification of proposed FEP team members, with special attention to scope of practice; need for any additional training; optimal case size; and plans for release from current duties.

2.7.1.1.5. Review of resources needed to implement the NAVIGATE program, with development of plans to access any resources currently not available at the agency.

2.7.1.1.6. Development of funding streams and strategies.

2.7.1.1.7. Discussion of plans for the prescriber regarding the time that shall be dedicated to regular meetings with clients, weekly team meetings and monthly consultation calls.

2.7.1.1.8. Responses to administrative or clinical leadership questions regarding NAVIGATE.

2.7.1.2. Telephone consultations with the Nashua CMHC that will prepare the agency to implement FEP NAVIGATE, on topics that include but are not limited to:

2.7.1.2.1. Strategies for program development.

2.7.1.2.2. Strategies for setting up the team.

2.7.1.2.3. Establishment of enrollment criteria.

2.7.1.2.4. Methods of working with private insurance and public assistance.

2.7.1.2.5. Development of a referral network.

2.7.1.2.6. Specific time that shall be set aside for staff to participate in team meetings and consultation calls.

2.7.1.2.7. Identification of outcome measures.

2.7.1.2.8. Establishment of materials and routines for outreach, referrals and engagement.

2.7.2. Phase 2 – Staff Training – The Contractor shall provide intensive 'hands-on' in-person training in the NAVIGATE components for the team(s). Intensive staff training shall include, but is not limited to:

2.7.2.1. Providing two (2) half-days of intensive Prescriber training.

2.7.2.2. Providing one (1) full day refresher in-person training for the Director/Family Clinician, IRTs and SEE.

2.7.2.3. Providing one (1) half-day of in-person Supervisor Training.

2.7.2.4. Providing Consultation calls for the Nashua CMHC team in the following manner:

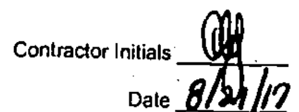
2.7.2.4.1. Twelve (12) calls for the Prescriber.

2.7.2.4.2. Eighteen (18) calls each for the Director/Family Clinician, IRT and SEE.

2.7.2.5. Providing one (1) day of in-person SEE training and site visit in the Nashua community.

2.7.3. Phase 3 – Consultation and Fidelity Monitoring for Successful Implementation – The Contractor shall ensure NAVIGATE Trainer/Consultants conduct follow-up telephone consultation to the Nashua CMHC on actively using NAVIGATE components, including trouble-shooting the overall implementation of the model (beginning the first month following the in-person training and continuing for up to one year following the in-person training). The Contractor shall:

2.7.3.1. Provide monthly consulting calls to the prescriber for up to twelve (12) months after completing the initial training.



2.7.3.2. Ensure prescriber fidelity by documenting prescriber practices and reviewing practices post implementation.

2.7.3.3. Ensure clinical fidelity by reviewing case presentations and reviewing random cases post implementation.

2.7.3.4. Conduct consultation calls once every two weeks to the Director/Family Clinician, IRT Clinician and SEE Specialist.

2.7.3.5. Tape and rate Family Clinician and IRT Fidelity Sessions to establish clinical fidelity, based on the fidelity scales established during the RAISE research phase of NAVIGATE.

2.7.3.6. Observe; by tape, joining by telephone or by on-site visit; and rate a minimum of four (4) team meetings to ensure Director Fidelity

2.7.3.7. Review regular summaries of weekly team meetings conducted by the Director to ensure Director Fidelity.

2.7.3.8. Ensure SEE Fidelity through review of:

2.7.3.8.1. Documentation of completed career inventories and community job development.

2.7.3.8.2. Record keeping on contacts with clients and community resources.

2.7.3.8.3. Case presentations.

2.7.3.9. Conduct a minimum of one (1) full day on-site observation of the SEE in the clinic and in the community.

2.7.4. Phase 4 – The Contractor shall evaluate procedures for the following seeking Clinical Certification:

2.7.4.1. One (1) Prescriber;

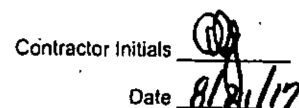
2.7.4.2. One (1) Director;

2.7.4.3. One (1) Family Clinician;

2.7.4.4. Two (2) IRTs; and

2.7.4.5. One (1) SEE.

2.8. The Contractor shall ensure FEP NAVIGATE trainees in the Nashua CMHC receive reference materials that supplement the trainings provided, including but not limited to:



2.8.1. Copies of the NAVIGATE Team Members' Guide for all team members.

2.8.2. Copies of the Director's Manuals, Family Education Manual, IRT manual, SEE manual and Prescriber's Manual, and links to Recovery Videos featuring clients and family members, for each Director receiving training.

2.8.3. Copies of the IRT Manual and links to the IRT videos for all IRT clinicians.

2.8.4. Copies of the Family Education Manual and links to Recovery videos featuring family members for all Family Education Clinicians.

2.8.5. Copies of the SEE manual and links to recovery videos featuring clients who are working and/or in school for all SEE Specialists.

2.8.6. Copies of the Prescriber's Manual and links to Recovery videos featuring clients talking about the role of medication in their recovery for all prescribers.

2.9. The Contractor shall evaluate certification requirements to FEP team members, which shall include, but not be limited to:

2.9.1. Requirements for prescriber certification, that include but are not limited to:

2.9.1.1. Participation in a minimum of ten (10) prescriber consultation calls.

2.9.1.2. Meeting fidelity criteria that include, but are not limited to:

2.9.1.2.1. Providing consultation data that indicates a minimum of 80% of clients served are being prescribed according to the NAVIGATE model.

2.9.1.2.2. Providing consultation data regarding laboratory result and how those results have been addressed.

2.9.2. Requirements for director certification, that include but are not limited to:

2.9.2.1. Participation in a minimum of fourteen (14) consultation calls, of which are scheduled twice per month for the first six (6) months and once per month for the second six (6) months.

2.9.2.2. Providing monthly written summary reports, in accordance with the Director Manual, to the Family

Clinician consultant, which shall include but not be limited to the number of following meetings that were held:

2.9.2.2.1. NAVIGATE team meetings.

2.9.2.2.2. IRT supervision.

2.9.2.2.3. Family supervision.

2.9.2.2.4. SEE supervison.

2.9.2.2.5. Collaborative treatment planning meetings.

2.9.2.2.6. Accompaniments of SEE specialist community visits.

2.9.2.3. Arranging a minimum of four (4) team meetings (one per quarter) that include the NAVIGANT consultant by speaker phone.

2.9.2.4. Responding to the NAVIGATE consultant's feedback on team meetings.

2.9.2.5. Meeting fidelity criteria that includes, but is not limited to:

2.9.2.5.1. Conducting a minimum of 80% of the required meetings.

2.9.2.5.2. Achieving an average of 3 on the Director Fidelity Scale for a minimum of three (3) team meetings that were observed.

2.9.2.5.3. Achieving an average of 3 on the Team Fidelity Scale as assessed by the NAVIGATE Director/Family consultant.

2.9.3. Requirements for IRT Clinician certification, that include but are not limited to:

2.9.3.1. Participation in a minimum of forty-two (42) weekly clinical meetings about IRT.

2.9.3.2. Audiotaping IRT sessions and completing IRT contact sheets.

2.9.3.3. Submitting taped IRT sessions and completed IRT contact sheets to the NAVIGATE IRT Consultant.

2.9.3.4. Responding to NAVIGATE consultant feedback on tapes and contact sheets providing in Section 2.7.3.3.

2.9.3.5. Submitting tapes from a minimum of two (2) clients at different stages of IRT.

2.9.3.6. Meeting IRT fidelity criteria for both standard and individualized modules, which includes but are not limited to:

2.9.3.6.1. Receiving a minimum rating of 3 on the IRT fidelity score for quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.

2.9.3.6.2. Receiving a minimum rating of 3 on the RIRT fidelity score for the overall quality of session item on a minimum of four (4) consecutive sessions, as assessed by the NAVIGATE Consultant.

2.9.4. Requirements for Family Clinician certification, that include but are not limited to:

2.9.4.1. Participation in a minimum of fourteen (14) consultation calls with the NAVIGATE Consultant.

2.9.4.2. Audiotaping family sessions and completing family contact sheets in accordance with the Family Consultant Manual.

2.9.4.3. Submitting taped family sessions and completed family contact sheets to the NAVIGATE Consultant.

2.9.4.4. Responding to the NAVIGATE Consultant's feedback regarding the sessions in Section 2.7.4.2.

2.9.4.5. Working with a minimum of two (2) families throughout the educational sessions to completion.

2.9.4.6. Meeting family clinician fidelity criteria, which include but are not limited to:

2.9.4.6.1. Receiving a rating of 3 on 'Overall quality of session' for 3 of the 4 rated sessions on a minimum of two (2) families, for a total of 8 rated sessions.

2.9.4.6.2. Audiotaping and submitting a minimum of one consultation session for a minimum of two (2) families to the NAVIGATE consultant for rating and feedback.

2.9.5. Requirements for SEE Specialist certification, that include but are not limited to:

2.9.5.1. Participating in a minimum of 42 meetings about SEE.

2.9.5.2. Participating in a one-day site visit with SEE NAVIGATE Consultant while conducting business in the community.

2.9.5.3. Providing sufficient information to the SEE NAVIGATE Consultant in order for the consultant to complete the NAVIGATE SEE Fidelity Scale, which may include role plays with the consultant in order to complete the entire assessment.

2.9.5.4. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to employment.

2.9.5.5. Presenting a minimum of one (1) case to the consultant that indicates supports in progress to education.

2.9.5.6. Meeting SEE Specialist Fidelity criteria, which include but are not limited to:

2.9.5.6.1. Demonstration of satisfactory performance on job development skills, educational opportunity development skills and observed interactions with clients, natural supports, employers and educators.

2.9.5.6.2. Demonstration of satisfactory ratings on the NAVIGATE SEE Fidelity Scale.

2.9.5.6.3. Presentation of a minimum of two (2) cases to the consultant showing evidence of fulfilling a minimum of 80% of SEE principles.

2.10. The Contractor shall provide Team Fidelity and Clinical Provider certification requirements to the Nashua CMHC, which shall include, but not be limited to:

2.10.1. Information that indicates FEP teams must provide fully integrated NAVIGATE services to a minimum of five (5) clients for a period of not less than nine (9) months.

2.10.2. Observation provided by NAVIGATE through consultation calls with the director, team meetings and reviews of records.

3. Reporting

3.1. The Contractor shall provide quarterly reports that include, but are not limited to:

3.1.1. A narrative summary of activities completed for the previous quarter that includes, but is not limited to:

3.1.1.1. Specific contacts made to Nashua CMHC.

3.1.1.2. Plan for the following quarter to overcome barriers experienced in the previous quarter.

3.1.2. Assessment of agencies and support provided to agencies for the purpose of readiness to implement the NAVIGATE program.

3.1.3. All reports provided pursuant to this contract will contain de-identified aggregate data only. No PHI, PII, or confidential information will be included. The Contractor shall not receive any PHI, PII or confidential information from any CMHC staff as a result of this contract.

4. Deliverables

4.1. The Contractor shall provide two (2) half-days of in-person training to the Prescribers from the Nashua CMHC to be completed within ninety (90) days of the contract effective date.

4.2. The Contractor shall provide one (1) day of refresher trainings, to be completed within ninety (90) days of the contract effective date, to the following positions:

4.2.1. Director of the Nashua CMHC;

4.2.2. Family clinician;

4.2.3. Individual Resiliency Trainers; and

4.2.4. Supported Employment and Education Specialist trainees.

4.3. The Contractor shall provide one (1) half-day of Supervisor training to be completed within ninety (90) days of the contract effective date.

4.4. The Contractor shall provide consultation calls within thirty (30) days of the completed training.

4.5. The Contractor shall begin the clinical certification process, which includes but may not be limited to:

4.5.1. Taping IRT and family sessions.

4.5.2. Reviewing SEE logs.

4.5.3. Reviewing psychiatrists prescribing practices.

4.6. The Contractor shall provide one (1) full day of SEE training and site visit in the Nashua community for Fidelity purposes as part of the clinical certification process by September 30, 2018.

4.7. The Contractor shall provide clinical certification for team members who meet clinical criteria by September 30, 2018.

Exhibit B

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. This contract is funded with federal funds. Department access to supporting funding for this project is dependent upon the criteria set forth in the Catalog of Federal Domestic Assistance (CFDA) (https://www.cfda.gov) #93.958 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Federal Award Identification Number (FAIN) #SM010035-17.
3. The Contractor shall use and apply all contract funds for authorized direct and indirect costs to provide services in Exhibit A, Scope of Services, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget.
4. The Contractor shall not use or apply contract funds for capital additions or improvements, entertainment costs, or any other costs not approved by the Department.
5. Payment for services provided in accordance with Exhibit A, Scope of Services, shall be made as follows:
   - 5.1. Payments shall be made on cost reimbursement basis only, for allowable expenses and in accordance with Exhibits B-1, Budget through Exhibit B-2, Budget.
   - 5.2. Allowable costs and expenses shall include those expenses detailed in Exhibit B-1, Budget through Exhibit B-2, Budget.
   - 5.3. The Contractor shall submit monthly invoices using invoice forms provided by the Department, and will reference contract budget detail on each invoice.
   - 5.4. The Contractor shall submit supporting documentation and required reports in Exhibit A, Scope of Services, Section 4, that support evidence of actual expenditures, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget for the previous month by the tenth (10th) working of the current month.
   - 5.5. The invoices for services outlined in Exhibit B-1, Budget, through Exhibit B-2 Budget shall be submitted preferably by e-mail on Department approved invoices to:

     State Planner or Designee
     Department of Health and Human Services
     Bureau of Mental Health Services
     105 Pleasant Street
     Concord, NH 03301

Contractor Initials: [signature]
Date: 8/21/17

Exhibit B

beth.nichols@dhhs.nh.gov

5.6. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement.

6. A final payment request shall be submitted no later than forty (40) days from the Form P37, General Provisions, Contract Completion Date, Block 1.7.

7. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Contract may be withheld, in whole or in part, in the event of noncompliance with any State or Federal law, rule or regulation applicable to the services provided, or if the said services have not been completed in accordance with the terms and conditions of this Agreement.

8. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to transfer the funds within the budgets in Exhibit B-1 and Exhibit B-2 and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

Exhibit B-1

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis
(Name of RFP)

Budget Period: State Fiscal Year (SFY) 2018, July 1, 2017 - 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	$ 1,625.00	$ 476.13	$ 2,101.13	$ -	$ -	$ -	$ 1,625.00	$ 476.13	$ 2,101.13
2. Employee Benefits	$ 568.75	$ 166.64	$ 735.39	$ -	$ -	$ -	$ 568.75	$ 166.64	$ 735.39
3. Consultants	$ 111,320.00	$ 32,616.76	$ 143,936.76	$ -	$ -	$ -	$ 111,320.00	$ 32,616.76	$ 143,936.76
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ 1,350.00	$ 395.55	$ 1,745.55	$ -	$ -	$ -	$ 1,350.00	$ 395.55	$ 1,745.55
6. Travel	$ 6,287.73	$ 1,842.30	$ 8,130.03	$ -	$ -	$ -	$ 6,287.73	$ 1,842.30	$ 8,130.03
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ 4,000.00	$ 1,172.00	$ 5,172.00	$ -	$ -	$ -	$ 4,000.00	$ 1,172.00	$ 5,172.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 125,151.48	$ 36,669.38	$ 161,820.86	$ -	$ -	$ -	$ 125,151.48	$ 36,669.38	$ 161,820.86
Indirect As A Percent of Direct		29.30%							

Contractors Initials _______

Date _______

Exhibit B-2

New Hampshire Department of Health and Human Services

Bidder/Program Name: Mary Hitchcock Memorial Hospital, Department of Psychiatry

Budget Request for: RFP-2017-DBH-05-FIRSTE/Trainer for First Episode Psychosis
(Name of RFP)

Budget Period: State Fiscal Year (SFY) 2019, July 1, 2018 - September 30, 2018

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Employee Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. Consultants	$ 26,774.00	$ 7,844.78	$ 34,618.78	$ -	$ -	$ -	$ 26,774.00	$ 7,844.78	$ 34,618.78
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
6. Travel	$ 560.53	$ 164.24	$ 724.77	$ -	$ -	$ -	$ 560.53	$ 164.24	$ 724.77
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	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 27,334.53	$ 8,009.02	$ 35,343.55	$ -	$ -	$ -	$ 27,334.53	$ 8,009.02	$ 35,343.55

Indirect As A Percent of Direct 29.30%

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 9.2 of the General Provisions of this contract, is amended to read:

   All materials developed by contractor or its subcontractors to provide the Services under this Agreement will remain the property of Contractor or its subcontractors.

3. Subparagraph 9.3 of the General Provisions of this contract, is amended to read:

   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; provided, however, prior written approval of the State shall not be required for Contractor of its agents or subcontractors to disclose the data solely for purposes of providing Services in accordance with this Agreement.

4. 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.

5. Subparagraph 14.1.2 of the General Provisions of this contract, Insurance, is deleted.

6. Subparagraph 15.2 of the General Provisions of this contract, is amended to read:

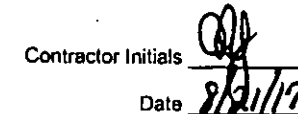
   To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement as required in N.H. RSA chapter 281-A. Contractor shall furnish the Contracting Officer identified in block 1.9, or his 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.

7. Paragraph 14, of the Special Provisions, Exhibit C, Prior Approval and Copyright Ownership is amended to read:

   All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. Contractor grants to the State an irrevocable, non-exclusive, worldwide, royalty-free right and license to use, reproduce, display, and distribute copies of all original materials produced, including, but not limited to, brochures, resource directors, protocols or guidelines, posters or reports, in the provision of these Services. The Contractor shall, and shall require any subcontractor or assignee to, obtain prior written approval from DHHS before using any information or data provided by the State in any materials to be used for purposes other than providing Services under this Agreement.

8. 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.

Contractor Initials



Date 8/21/17

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:

8/21/17
Date

Name: Daniel P. Jantzen
Title: Chief Financial 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:

8/21/17
Date

Name: Daniel Jantzen
Title: Chief Financial Officer

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:

8/21/17
Date

Name: Daniel P. Janzen
Title: Chief Financial Officer

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

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

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

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

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

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

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

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

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

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

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

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

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

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:

8/21/17
Date

Name: Daniel J. Dantzen
Title: Chief Financial Officer

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:

8/21/17
Date

Name: Daniel P. Jantzen
Title: Chief Financial Officer

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

Reserved

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:

8/21/17
Date

Name: Daniel P. Jantzen
Title: Chief Financial Officer

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: ____________