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STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

Lori A. Shibinette
Commissioner

Lisa M. Morris
Director

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October 21, 2020

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

INFORMATIONAL ITEM

Pursuant to RSA 4:45, RSA 21-P:43, and Section 4 of Executive Order 2020-04 as extended by Executive Orders 2020-05, 2020-08, 2020-09, 2020-10, 2020-14, 2020-15, 2020-16, 2020-17, 2020-18, and 2020-20, Governor Sununu has authorized the Department of Health and Human Services, Division of Public Health Services, to enter into a **Retroactive, Sole Source** contract with Alice Peck Day Memorial Hospital (VC#177173), Lebanon, NH, in the amount of $145,000, to conduct hospital-based COVID-19 community testing and testing-related activities, with the option to renew for up to one (1) additional year, effective retroactive to September 1, 2020, through December 1, 2020. 100% Federal Funds.

Funds are available in the following account for State Fiscal Year 2021, with the authority to adjust budget line items within the price limitation through the Budget Office, if needed and justified.

05-095-090-903010-19010000 HEALTH AND SOCIAL SERVICES, HEALTH AND HUMAN SVCS DEPT OF, HHS: PUBLIC HEALTH DIVISION, BUREAU OF LABORATORY SERVICES, ELC CARES COVID-19

State Fiscal Year	Class / Account	Class Title	Job Number	Total Amount
2021	102-500731	Contracts for Prog Svc	90183518	$145,000
			Total	**$145,000**

EXPLANATION

This contract is **Retroactive** because more time was needed to negotiate and finalize the scope of the work prior to the Contractor accepting the terms of the agreement. This contract is **Sole Source** because the Department, in the interest of the public's health and safety, identified hospitals with catchment areas throughout New Hampshire and capacity to immediately begin conducting community COVID-19 testing and testing-related activities. The Contractor is uniquely qualified to provide COVID-19 testing to individuals who reside within the hospital's catchment area or local community.

The Contractor is conducting COVID-19 specimen collection and testing for individuals who reside within each hospital's catchment area or local community, regardless of the individuals' prior affiliations with the hospital. The Contractor is testing individuals who have

symptoms of COVID-19, who are pre-symptomatic, or asymptomatic at the request of the individuals to be tested or the Department. The Contractor will also utilize various communication methods, including the hospitals' websites, newsletters, and social media platforms, to inform the local community members how and when they can access the services and the location of the specimen collection sites.

The exact number of residents of the State of New Hampshire served from September 1, 2020, to December 1, 2020, will depend on the trajectory of the COVID-19 pandemic.

The Department will monitor contracted services by requiring the Contractor to report:

- Number of persons who received COVID-19 testing.
- Number of persons assisted with enrollment in the Medicaid COVID-19 Testing benefit or other assistance program who received COVID-19 testing.
- Number of persons for whom race and/or ethnicity is documented.
- Allowable expenses incurred during the duration of the contract.

As referenced in Exhibit A Revisions to Standard Contract Provisions, Section 1, Revisions to Form P-37, General Provisions, Subsection 1.2., Paragraph 3.3 of the attached contracts, the parties have the option to extend the agreements for up to one (1) additional year, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and appropriate State approval.

Areas served: Statewide

Source of Funds: 100% Federal Funds. CFDA #93.323, FAIN #NU50CK000522

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

Respectfully submitted,

Lori Shibinette

Lori A. Shibinette
Commissioner

Subject: Hospital-Based COVID-19 Community Testing (SS-2021-DPHS-04-HOSPI-22)

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 New Hampshire Department of Health and Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301-3857	
1.3 Contractor Name Alice Peck Day Memorial Hospital		1.4 Contractor Address 10 Alice Peck Day Drive Lebanon, NH 03766	
1.5 Contractor Phone Number (603) 448-3121	1.6 Account Number 05-095-090-903010-19010000	1.7 Completion Date December 1, 2020	1.8 Price Limitation $145,000
1.9 Contracting Officer for State Agency Nathan D. White, Director		1.10 State Agency Telephone Number (603) 271-9631	
1.11 Contractor Signature Sue E Mooney Date: 8/24/20		1.12 Name and Title of Contractor Signatory Sue Eliese Mooney President and CEO	
1.13 State Agency Signature Lori Shibinette Date: 9/1/2020		1.14 Name and Title of State Agency Signatory Lori Shibinette, Commissioner	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: Catherine Pinos		On: 09/08/20	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

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

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

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

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

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

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

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

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

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

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

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

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

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

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

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

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

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

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

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

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

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

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

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

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

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REVISIONS TO STANDARD CONTRACT PROVISIONS

1. Revisions to Form P-37, General Provisions

1.1. Paragraph 3, Subparagraph 3.1, Effective Date/Completion of Services, is amended as follows:

3.1. Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor of the State of New Hampshire, issued under the Executive Order 2020-04 and any extensions thereof, this Agreement, and all obligations of the parties hereunder, shall become effective on September 1, 2020. ("Effective Date").

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

3.3. The parties may extend the Agreement for up to one (1) additional year from the Completion Date, contingent upon satisfactory delivery of services, available funding, agreement of the parties, and required governmental approval.

1.3. Paragraph 9, Termination, is deleted in its entirety and replaced as follows:

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2. The Contractor may terminate the Agreement by providing the State with thirty (30) days advance written notice if the State fails to pay the undisputed amount of any expense report submitted by Contractor pursuant to Exhibit C within thirty (30) days after the date of the report; however, upon receipt of such notification the State has an additional twenty (20) days to make payment of undisputed amounts to avoid termination. In addition, the Contractor may terminate this Agreement by providing the State with thirty (30) days advance written notice if it makes a good faith determination that either (i) the fulfillment of its obligations under the Agreement has been or is reasonably likely to be adversely impacted by a shortage of supplies or disruption to the supply chain; or (ii) the continued performance of services hereunder would adversely impact the ability of the Contractor to meet the testing needs of its patients (each an "Adverse Impact"). Promptly following Contractor's submission of such notice of termination, the Parties shall work together in good faith with the goal of mutually agreeing upon modifications to the scope of services and/or other obligations of Contractor under the Agreement to mitigate the Adverse Impact upon the Contractor during the notification period ("Workaround Plan");

provided, however, that if the Parties are unable to mutually agree on a Workaround Plan within five (5) business days after Contractor provides written notice of termination to the Department as a result of an Adverse Impact, the Contractor may, upon written notice to the Department, decrease the number of specimens collected and tested hereunder for the remainder of the notice period, as determined by Contractor in its reasonable discretion.

9.3 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed; and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

1.4. Paragraph 12, Subparagraph 12.3, Assignment/Delegation/Subcontracts, is amended as follows:

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

1.5. Paragraph 14, Subparagraph 14.2, Insurance, is amended as follows:

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.

Scope of Services

1. **Statement of Work**

1.1. For the purposes of this agreement, any references to days shall mean calendar days.

1.2. Contractor shall conduct specimen collection and testing for SARS-CoV-2 in an outpatient setting for pre-procedural hospital patients and individuals referred by primary care providers within the Dartmouth-Hitchcock Health system no later than September 1, 2020.

1.3. The Contractor shall begin conducting specimen collection and testing for SARS-CoV-2 in an outpatient setting as capacity allows to meet the defined community demand (Monday to Friday) during the term of the Agreement for New Hampshire residents residing within the Lebanon Health Care Service Area, as defined in Contractor's U.S. Department of Treasury, Internal Revenue Service Form 990 (Return of Organization Exempt from Income Tax), regardless of individuals' prior affiliations with the Dartmouth-Hitchcock Health system no later than November 1, 2020.

1.4. The Contractor shall use commercially reasonable efforts to conduct specimen collection and testing for patients who have symptoms of COVID-19 or who are pre-symptomatic or asymptomatic at the request of:

1.4.1. The individual to be tested; or

1.4.2. The Department of Health and Human Services (Department) Division of Public Health Services (DPHS).

1.5. Notwithstanding the foregoing, Contractor reserves the right to limit specimen collection and testing services hereunder, from time to time, to ensure that its capacity remains sufficient to meet the needs of its patients and/or defined community demand.

1.6. The Contractor shall not require an office or telemedicine visit for asymptomatic patients in order for patients to receive COVID-19 testing.

1.7. In the event of a significant increase in community transmission of COVID-19, the Contractor shall not be responsible for meeting significantly increased levels of testing and may request the Department to provide additional testing capacity.

1.8. The Contractor shall determine the appropriate venue and physical location for specimen collection, which may include, but is not limited to:

1.8.1. An existing physical location.

1.8.2. A temporary drive-through location.

1.8.3. A drive-up facility.

1.9. The Contractor shall request a waiver, if necessary, from the Department's Bureau of Health Facilities Administration for a temporary drive-through location or drive-up facility.

1.10. The Contractor shall determine the appropriate number of days per week and the duration of time per day to perform community specimen collection for COVID-19 testing to meet the needs of the defined community demand and communicate the hours of operation to the Department.

1.11. The Contractor shall ensure the collection, handling, processing and testing of specimens comply with guidelines issued by the Centers for Disease Control and Prevention (CDC), available at https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html and by the laboratory used for processing specimens.

1.12. The Contractor shall obtain patient consent, prior to collection of specimens, authorizing testing at the laboratory and reporting to the ordering medical provider, the Department, and any other individual or entity designated to receive the test results.

1.13. The Contractor shall use commercially reasonable efforts to identify any communication access needs to ensure needed language assistance is provided, which may include, but is not limited to:

1.13.1. Over-the-phone interpretation of spoken languages.

1.13.2. American Sign Language interpreters with at least forty-eight (48) hours advance notice.

1.14. The Contractor shall ensure communication and language assistance is provided to individuals, as appropriate and needed, to ensure the validity of any consent by utilizing translated consent forms and/or interpreters.

1.15. The Contractor shall ensure all personnel collecting, handling, processing and transporting specimens are trained to safeguard the confidentiality of the patient and protected health information (PHI), as defined in the Health Information Portability and Accountability Act (HIPAA).

1.16. The Contractor shall ensure the secure and confidential transporting of specimens to the laboratory.

1.17. The Contractor shall ensure the ordering provider for each COVID-19 test is a licensed medical provider to the extent applicable.

1.18. The Contractor shall notify the licensed medical provider ordering a COVID-19 test for a patient of testing results received from the laboratory in a timely manner. The Contractor shall ensure:

1.18.1. Patients with positive results confirming the diagnosis of COVID-19 are informed:

1.18.1.1. By telephone or other electronic method.

1.18.1.2. By first-class U.S. mail, if telephone or other electronic method is unsuccessful

1.18.2. Patients with negative results are informed of test results in a method determined by the Contractor.

1.19. The Contractor shall utilize existing communication methods to inform the local community of the availability of outpatient COVID-19 testing, which may include, but are not limited to:

1.19.1. The hospital's website.

1.19.2. Hospital newsletters.

1.19.3. Social media platforms.

1.20. The Contractor shall ensure published information includes how and when patients can access the services and the location of the specimen collection site.

1.21. The Contractor shall ensure any marketing materials abide by existing requirements for communication access, including but not limited to:

1.21.1. Vital and significant materials should be made available in additional languages, as appropriate, and must be translated by qualified, competent translation providers, as follows:

1.21.1.1. Statewide, only Spanish meets the criteria for translation.

1.21.1.2. Translation is required for languages depending on factors including the number and proportion of LEP persons served or likely to seek services in the Contractor's service areas, and the frequency with which LEP individuals come into contact with the Contractor's programs, activities and services.

1.21.1.3. Notification on all materials of the availability of free communication access and language assistance for any individuals who may require it.

1.21.1.4. All materials have a phone number to call for further information, ensuring staff answering that phone number shall have access to over-the-phone interpretation to assist callers who need spoken language interpretation.

1.22. The Contractor shall provide communication and language assistance at the hospital to assist individuals accessing COVID-19 testing with communication access needs, including individuals with limited English proficiency, or individuals who are deaf or have hearing loss.

1.23. As of the start date for specimen collection and testing services pursuant to Paragraph 1.3 above, the Contractor shall begin to conduct outreach to vulnerable populations and minority populations in the hospital catchment area or local community, including notifying partner organizations who work with these populations about the availability of COVID-19 testing.

1.24. The Contractor shall require the laboratory to report both positive and negative test results to the Division of Public Health Services through the Electronic Laboratory Reporting (ELR) system, or ensure the laboratory used for processing specimens and conducting testing reports both positive and negative results to the Division of Public Health Services through the ELR system.

1.25. The Contractor shall require the laboratory to report all positive cases of COVID-19 with complete case information by fax to (603) 271-0545 to the Division of Public Health Services using the New Hampshire Confidential COVID-19 Case Report Form available at: https://www.dhhs.nh.gov/dphs/cdcs/covid19/covid19-reporting-form.pdf.

1.26. The Contractor shall use commercially reasonable efforts to: (a) notify patients who are uninsured or do not have full coverage benefits for COVID-19 testing that New Hampshire Medicaid has established a COVID-19 Testing Benefit that may pay for testing and diagnosis of COVID-19 for persons who are not already a Medicaid beneficiary and do not have full coverage for COVID-19 testing and diagnosis; and (b) assist patients in completing the application available at https://nheasy.nh.gov.

2. Exhibits Incorporated/Confidential Data

2.1. The Contractor shall use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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

2.3. The Contractor's Use and Responsibilities for Confidential Information are as follows.

2.3.1. The Contractor agrees to use, disclose, maintain, or transmit Confidential Data from Providers as required, specifically authorized, or permitted under the Contract or this Agreement. Further, the Contractor, including but not limited to all its directors, officers, employees, and agents, agrees not to use, disclose, maintain, or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rules. The Contractor shall provide Confidential Information as required by the Contract, RSA 141-C:7, 141-C:9, RSA 141-C:10, and in a form

required by He-P 301.03 and the "New Hampshire Local Implementation Guide for Electronic Laboratory Reporting for Communicable Disease and Lead Test Results Using HL7 2.5.1," Version 4.0 (5/23/2016), found at: https://www.dhhs.nh.gov/dphs/bphsi/documents/elrguide.pdf.

2.3.2. The Contractor shall transmit Confidential Information to the Division of Public Health Services by means of a secure file transport protocol (sFTP) provided by the Department and agreed to by the parties and approved by the Department's Information Security Officer.

2.3.3. The Contractor shall transmit the Confidential Information to the Division of Public Health Services as required by statute and this Agreement, namely:

2.3.3.1. All test results, including but not limited to positive and negative results, shall be reported electronically via electronic laboratory reporting procedures, also referred to as "ELR," as noted above.

2.4. s necessary, the Contractor agrees to comply with any request to correct or complete the data once transmitted to the Division of Public Health Services.

2.5. The Contractor agrees that the data submitted shall be the "minimum necessary" to carry out the stated use of the data, as defined in the HIPAA Privacy Rule and in accordance with all applicable confidentiality laws.

2.6. The parties agree that this Agreement shall be construed in accordance the terms of Contract and governed by the laws of the State of New Hampshire.

2.7. The Contractor and the Department agree to negotiate an amendment to this Agreement as needed to address a Contract amendment, or any changes in policy issues, fiscal issues, information security, and other specific safeguards required for maintaining confidentiality of the data.

3. Reporting Requirements

3.1. The Contractor shall submit monthly reports to the Department showing that the public is able to access COVID-19 testing, including, but not limited to:

3.1.1. Number of persons who received COVID-19 testing.

3.1.2. Number of persons assisted with enrollment in the Medicaid COVID-19 Testing benefit or other assistance program who received COVID-19 testing.

3.1.3. Number of persons for whom race and/or ethnicity is documented.

3.2. The Contractor shall use commercially reasonable efforts to document race and/or ethnicity demographic identifiers for the persons who received COVID-19 testing, in accordance with best practice standards and processes as provided by the Office of Health Equity, and enter these identifiers either

manually or electronically on the hospital or reference laboratory COVID-19 test requisition forms.

4. Additional Terms

4.1. Impacts Resulting from Court Orders or Legislative Changes

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

4.2. Federal Civil Rights Laws Compliance: Culturally and Linguistically Appropriate Programs and Services

4.2.1. The Contractor shall submit within thirty (30) days of the contract effective date, and comply with, a detailed description of the communication access and language assistance services they will provide to ensure meaningful access to their programs and/or services to persons with limited English proficiency, people who are deaf or have hearing loss, are blind or have low vision, or who have speech challenges.

4.3. Credits and Copyright Ownership

4.3.1. All documents, notices, press releases, research reports and other materials prepared by Contractor as a result of the performance of the services hereunder, which are created as of the Effective Date of the Agreement and for which the costs and expenses are reimbursed hereunder as an allowable expense, shall include the following statement, "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."

4.3.2. All materials produced or purchased under the contract shall have prior approval from the Department before printing, production, distribution or use.

4.4. Operation of Facilities: Compliance with Laws and Regulations

4.4.1. 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.

4.5. **Force Majeure**

4.5.1. Any delays in performance by a party under the contract shall not be considered a breach of the contract if and to the extent caused by occurrences beyond the reasonable control of the party affected: acts of God, embargoes, governmental restrictions, strikes, pandemics, fire, earthquake, flood, explosion, riots, wars, civil disorder, rebellion, or sabotage. The party suffering such occurrence shall immediately notify the other party of the occurrence of the Force Majeure event (in reasonable detail) and the expected duration of the event's effect on the party. A disruption in a party's performance due to Force Majeure extending beyond a stated period may be the cause for termination of the Contract at the sole discretion of the State. The State reserves the right to extend any time for performance by the actual time of the delay caused by the occurrence, provided that the party affected by the event uses reasonable efforts to overcome such delay. Notwithstanding anything in this provision, Force Majeure shall not include the novel coronavirus COVID-19 pandemic which is ongoing as of the date of the execution of this Contract. In the event that the Contractor's performance under the contract may be delayed due to a supply chain disruption or shortage and/or other similar occurrences completely outside of Contractor's control, the Contractor must notify the State of such delay and the State, at its sole discretion, may modify the delivery of services due to the circumstances. Said discretion on the part of the State to modify the delivery of services will not be unreasonably withheld, delayed, or conditioned.

5. Records

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

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

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

5.1.3. Statistical, enrollment, attendance or visit records for each recipient of services, 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.

5.1.4. Medical records on each patient/recipient of services.

5.2. 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. 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.

Payment Terms

1. This Agreement is funded by the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement from the Centers for Disease Control and Prevention Division of Prepardness and Emerging Infections, CFDA #93.323, FAIN #NU50CK000522.
2. For the purposes of this Agreement:
   - 2.1. The Department has identified the Contractor as a Subrecipient, in accordance with 2 CFR 200.330.
   - 2.2. The Department has identified this Contract as NON-R&D, in accordance with 2 CFR §200.87.
3. This Agreement is for COVID-19 testing and testing-related activities to be conducted between September 1, 2020 and December 1, 2020.
4. Payment:
   - 4.1. The Department will pay the Contractor the amount listed in box 1.8 Price Limitation included in the General Provisions Form Number P-37, for providing the services included in Exhibit B, Scope of Services, after the Effective Date of the Contract.
     - 4.1.1. The Contractor shall submit an expense report in a form satisfactory to the State every sixty (60) days, which identifies allowable expenses incurred during the duration of the contract.
     - 4.1.2. Without limiting the foregoing, and notwithstanding Paragraph 7.1 of P-37 (General Terms), the term "allowable expenses" shall include personnel costs incurred by Contractor in connection with the performance of services included in Exhibit B, Scope of Services.
     - 4.1.3. Any unspent start-up payment funds will be returned to the Department within sixty (60) calendar days of contract expiration date.
     - 4.1.4. In lieu of hard copies, all expense reports may be assigned an electronic signature and must be emailed to dphscontractbilling@dhhs.nh.gov.
5. The Contractor must provide the services in Exhibit B, Scope of Services, in compliance with funding requirements.
6. The Contractor agrees that funding under this Agreement may be recouped, in whole or in part in the event of non-compliance with the terms and conditions of Exhibit B, Scope of Services.

7. The Contractor shall keep detailed records of their activities related to Department-funded programs and services and have records available for Department review, as requested.

8. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be recouped, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.

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

10. Audits

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

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

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

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

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

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

10.4. In addition to, and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions

and shall return to the Department all payments made under the Contract to which exception has been taken, or which have been disallowed because of such an exception.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The Vendor 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.

Vendor Name:
Susan E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title: Pres/CEO

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Vendor Name: Susan E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title: Pres/CEO

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Vendor 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.

Vendor Name:
Susan E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title:

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

The Vendor 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:

Vendor 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 Vendor 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 Vendor agrees to comply with the provisions indicated above.

Vendor Name:
Susan E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title: Pres/CEO

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 Vendor 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 Vendor 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.

Vendor Name:
Susan E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title: Pres/CEO

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) BUSINESS ASSOCIATE AGREEMENT

Exhibit I is not applicable to this Agreement.

Remainder of page intentionally left blank.

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:
A-c E Mooney

8/24/20
Date

Susan E. Mooney
Name:
Title: Pres/CEO

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: 073991648

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: _____

A. Definitions

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

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

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

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

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

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

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

6. "Incident" means an act that potentially violates a security policy, which includes successful attempts) to gain unauthorized access to a system or its data, unwanted disruption or denial of service, the unauthorized use of a system for the processing or

storage of data; and changes to system hardware, firmware, or software characteristics without the owner's knowledge, instruction, or consent. Incidents include the loss of data through theft or device misplacement, loss or misplacement of hardcopy documents, and misrouting of physical or electronic documents or mail.

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

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

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

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

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

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

I. RESPONSIBILITIES OF DHHS AND THE CONTRACTOR

A. Business Use and Disclosure of Confidential Information.

1. The Contractor must not use, disclose, maintain or transmit Confidential Information

except as required or permitted under this Contract or required by law. Further, Contractor, including but not limited to all its directors, officers, employees and agents, must not use, disclose, maintain or transmit PHI in any manner that would constitute a violation of the Privacy and Security Rule.

2. The Contractor must not disclose any Confidential Information in response to a request for disclosure on the basis that it is required by law, in response to a subpoena, etc., without first notifying DHHS so that DHHS has an opportunity to consent or object to the disclosure.
3. The Contractor agrees that DHHS Data or derivative there from disclosed to an End User must only be used pursuant to the terms of this Contract.

II. METHODS OF SECURE TRANSMISSION OF DATA

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

access or transmit Confidential Data, a secure method of transmission or remote access, which complies with the terms and conditions of Exhibit K, must be used.

10. SSH File Transfer Protocol (SFTP), also known as Secure File Transfer Protocol. If Contractor is employing an SFTP to transmit Confidential Data, End User will structure the Folder and access privileges to prevent inappropriate disclosure of information. SFTP folders and sub-folders used for transmitting Confidential Data will be coded for 24-hour auto-deletion cycle (i.e. Confidential Data will be deleted every 24 hours).
11. Wireless Devices. If Contractor is transmitting Confidential Data via wireless devices, all data must be encrypted to prevent inappropriate disclosure of information.

III. RETENTION AND DISPOSITION OF IDENTIFIABLE RECORDS

The Contractor will only retain DHHS Data and any derivative of the data for the duration of this Contract. After such time, the Contractor will have thirty (30) days to destroy the data and any derivative in whatever form it may exist, unless, otherwise required by law or, if it is infeasible to return or destroy DHHS Data, protections are extended to such information, in accordance with the termination provisions in this Section. To this end, the parties must:

A. Retention

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

maintained anti-malware (e.g. anti-viral, anti-hacker, anti-spam, anti-spyware) utilities. The environment, as a whole, must have aggressive intrusion-detection and firewall protection.

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

B. Disposition

If the Contractor maintains any Confidential Information on its systems (or its sub-contractor systems) and it has not done so previously, the Contractor will implement policies and procedures to ensure that any storage media on which such data maybe recorded will be rendered unreadable and that the data will be un-recoverable when the storage media is disposed of. Upon request, the Contractor will provide the Department with copies of these policies and with written documentation demonstrating compliance with the policies. The written documentation will include all details necessary to demonstrate data contained in the storage media has been rendered unreadable and un-recoverable. Where applicable, regulatory and professional standards for retention requirements may be jointly evaluated by the State and Contractor prior to destruction.

1. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to destroy all hard copies of Confidential Data using a secure method such as shredding.
2. Unless otherwise specified, within thirty (30) days of the termination of this Contract, Contractor agrees to completely destroy all electronic Confidential Data by means of data erasure, also known as secure data wiping.

IV. PROCEDURES FOR SECURITY

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

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

2. The Contractor will maintain policies and procedures to protect Department confidential information throughout the information lifecycle, where applicable, (from creation, transformation, use, storage and secure destruction) regardless of the media

used to store the data (i.e., tape, disk, paper, etc.).

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

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

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

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

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

8. Data Security Breach Liability. In the event of any computer security incident, incident, or breach Contractor shall make efforts to investigate the causes of the breach, promptly take measures to prevent future breach and minimize any damage or loss resulting from the breach. The State shall recover from the Contractor all costs of response and recovery from the breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services necessary due to the breach.

9. Contractor must, comply with all applicable statutes and regulations regarding the privacy and security of Confidential Information, and must in all other respects maintain the privacy and security of PI and PHI at a level and scope that is not less than the level and scope of, HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164) and 42 C.F.R. Part 2 that govern protections for individually identifiable

health information and as applicable under State law.

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

11. Contractor agrees to maintain a documented breach notification and incident response process. The Contractor must notify the DHHS Security Office and the Program Contact via the email addresses provided in Section VI of this Exhibit, immediately upon the Contractor determining that a breach or security incident has occurred and that DHHS confidential Information/data may have been exposed or compromised. This includes a confidential information breach, computer security incident, or suspected breach which affects or includes any State of New Hampshire systems that connect to the State of New Hampshire network.

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

13. The Contractor is responsible for End User oversight and compliance with the terms and conditions of the contract and Exhibit K.

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

V. LOSS REPORTING

The Contractor must immediately notify the State's Privacy Officer, Information Security Office and Program Manager of any Security Incidents and Breaches as specified in Section IV, paragraph 11 above.

The Contractor must further handle and report Incidents and Breaches involving PHI in accordance with DHHS's documented Incident Handling and Breach Notification procedures and in accordance with– the HIPAA, Privacy and Security Rules. In addition

to, and notwithstanding, Contractor's compliance with all applicable obligations and procedures, Contractor's procedures must also address how the Contractor will:

1. Identify Incidents;
2. Determine if personally identifiable information is involved in Incidents;
3. Report suspected or confirmed Incidents as required in this Exhibit or P-37;
4. Identify and convene a core response group to determine the risk level of Incidents and determine risk-based responses to Incidents; and
5. Determine whether Breach notification is required, and, if so, identify appropriate Breach notification methods, timing, source, and contents from among different options, and bear costs associated with the Breach notice as well as any mitigation measures.

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

VI. PERSONS TO CONTACT

A. DHHS contact for Data Management or Data Exchange issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

B. DHHS contacts for Privacy issues:
DHHSPrivacyOfficer@dhhs.nh.gov

C. DHHS contact for Information Security issues:
DHHSInformationSecurityOffice@dhhs.nh.gov

D. DHHS contact for Breach notifications:
DHHSInformationSecurityOffice@dhhs.nh.gov
DHHSPrivacyOfficer@dhhs.nh.gov

E. DHHS Program Area Contact:
Christine.Bean@dhhs.nh.gov

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 ALICE PECK DAY MEMORIAL HOSPITAL is a New Hampshire Nonprofit Corporation registered to transact business in New Hampshire on November 17, 1930. 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: **60181**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 6th day of December A.D. 2017.

William M. Gardner
Secretary of State

CERTIFICATE OF AUTHORITY

I, Michael Long, hereby certify that:
(Name of the elected Officer of the Corporation/LLC; cannot be contract signatory)

1. I am a duly elected Clerk/Secretary/Officer of Alice Peck Day Memorial Hospital
(Corporation/LLC Name)

2. The following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on March 28, 2019, at which a quorum of the Directors/shareholders were present and voting.
(Date)

VOTED: That Susan E. Mooney (may list more than one person)
(Name and Title of Contract Signatory)

is duly authorized on behalf of APD to enter into contracts or agreements with the State
(Name of Corporation/ LLC)

of New Hampshire and any of its agencies or departments and further is authorized to execute any and all documents, agreements and other instruments, and any amendments, revisions, or modifications thereto, which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

3. I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract/contract amendment to which this certificate is attached. This authority **remains valid for thirty (30)** days from the date of this Certificate of Authority. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person(s) listed above currently occupy the position(s) indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein.

Dated: 9/2/2020

Michael A. Long
Signature of Elected Officer
Name: Michael Long
Title: APDMH Secretary

CERTIFICATE OF INSURANCE

DATE: August 24, 2020

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

INSURED
Alice Peck Day Memorial Hospital
10 Alice Peck Day Drive
Lebanon, NH 03766

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

COVERAGES

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

TYPE OF INSURANCE		POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002020-A	07/01/2020	07/01/2021	EACH OCCURRENCE	$1,000,000
					DAMAGE TO RENTED PREMISES	$100,000
X	CLAIMS MADE				MEDICAL EXPENSES	N/A
					PERSONAL & ADV INJURY	$1,000,000
	OCCURRENCE				GENERAL AGGREGATE	$2.000,000
OTHER					PRODUCTS-COMP/OP AGG	$1,000,000
PROFESSIONAL LIABILITY					EACH CLAIM	
	CLAIMS MADE				ANNUAL AGGREGATE	
	OCCURENCE					
OTHER						

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

Certificate is supplied as evidence of insurance only for purpose of a community COVID-19 testing contract.

CERTIFICATE HOLDER

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

CANCELLATION
Should any of the above described policies be cancelled before the expiration date thereof, 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 LSTILES

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 9/2/2020

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

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

PRODUCER License # 1780862 HUB International New England 275 US Route 1 Cumberland Foreside, ME 04110	CONTACT NAME: Nicole Goodrich PHONE (A/C, No, Ext): (617) 528-4903 FAX (A/C, No): E-MAIL ADDRESS: nicole.goodrich@hubinternational.com
	INSURER(S) AFFORDING COVERAGE — NAIC #
	INSURER A : Safety National Casualty Corporation — 15105
INSURED Dartmouth-Hitchcock Health 1 Medical Center Dr. Lebanon, NH 03756	INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						X PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐	N / A		AGC4063394	7/1/2020	7/1/2021	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						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

Cheshire Medical Center
Dartmouth-Hitchcock Health
Mary Hitchcock Memorial Hospital
Alice Peck Day Memorial Hospital
New London Hospital Association
Mt. Ascutney Hospital and Health Center

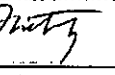
CERTIFICATE HOLDER

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



ALICE PECK DAY
MEMORIAL HOSPITAL

A Dartmouth-Hitchcock Affiliate

APD's mission is to improve the health and wellbeing of our community.

-Affirmed by Board of Trustees in July, 2019

Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2019 and 2018

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

Management's Responsibility for the Consolidated Financial Statements

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

Auditors' Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.
An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Health System's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

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

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Emphasis of Matter

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

Other Matter

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

PricewaterhouseCoopers LLP

Boston, Massachusetts
November 26, 2019

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

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

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

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

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

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 - Continued
Years Ended June 30, 2019 and 2018

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

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

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

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

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

1. Organization and Community Benefit Commitments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(in thousands of dollars)

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

2. Summary of Significant Accounting Policies

Basis of Presentation

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

Use of Estimates

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

Excess of Revenue over Expenses

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

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

Charity Care

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

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

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

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

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

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

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

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

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

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

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

Level 1 — Unadjusted quoted prices in active markets that are accessible at the measurement date for assets or liabilities.

Level 2 — Prices other than quoted prices in active markets that are either directly or indirectly observable as of the date of measurement.

Level 3 — Prices or valuation techniques that are both significant to the fair value measurement and unobservable.

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

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

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

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

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

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

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

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

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets, specific firm commitments or forecasted transactions. The Health System also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in variability of cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in net assets without donor restrictions until earnings are affected by the

variability in cash flows of the designated hedged item. The ineffective portion of the change in fair value of a cash flow hedge is reported in excess of revenue over expenses in the consolidated statements of operations and changes in net assets.

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

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

Gifts
Gifts without donor restrictions are recorded net of related expenses as non-operating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair value at the date the gift is received. Gifts are reported with donor restrictions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified as net assets without donor restrictions and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

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

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

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

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

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

3. Acquisitions

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

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

4. Patient Service Revenue and Accounts Receivable

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

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

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

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

Hospitals are paid amounts negotiated with insurance companies or set by government entities, which are typically less than established or standard charges. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care

contracts. Gross charges are what hospitals charge all patients prior to the application of contractual adjustments and implicit price concessions.

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

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

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

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

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

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

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

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

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

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

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

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

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

2018, the Health System recognized as revenue DSH receipts of approximately $64,864,000 and approximately $54,469,000, respectively.

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

Implicit Price Concessions

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

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

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

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

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

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

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

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

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

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

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

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

5. Investments

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

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

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

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

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

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

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

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

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

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

6. Property, Plant, and Equipment

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

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

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

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

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

7. Fair Value Measurements

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

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

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

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

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Health System believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

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

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

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

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

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

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

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

8. Net Assets with Donor Restrictions

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

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

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

9. Board Designated and Endowment Funds

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Long-Term Debt

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

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

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

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

*Represents nonobligated group bonds

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

(in thousands of dollars)	2019
2020	$ 10,914
2021	10,693
2022	10,843
2023	7,980
2024	3,016
Thereafter	699,639
	$ 743,085

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds

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

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

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

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

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

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

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

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

(4) Series 2018C Revenue Bonds

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

(5) Series 2012 Revenue Bonds

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

(6) Series 2016B Revenue Bonds

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

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

Non Obligated Group Bonds

(7) Series 2010 Revenue Bonds

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

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

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

Swap Agreements

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

As of June 30, 2019 and 2018, there was no liability for interest rate swaps as all remaining swaps were terminated in February 2018. For the year ended June 30, 2018, the Health System recognized a non-operating loss due to swap termination of $14,247,000 relating to the swap termination. The change in fair value during the year ended June 30, 2018 was a decrease of

$4,897,000. For the year ended June 30, 2018 the Health System recognized a non-operating gain of $145,000 resulting from hedge ineffectiveness and amortization of frozen swaps.

11. Employee Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(in thousands of dollars)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12. Professional and General Liability Insurance Coverage

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

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

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

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

13. Commitments and Contingencies

Litigation

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

Operating Leases and Other Commitments

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

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

(in thousands of dollars)

2020	$ 11,342
2021	10,469
2022	7,488
2023	6,303
2024	4,127
Thereafter	5,752
	$ 45,481

Lines of Credit

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

14. Functional Expenses

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

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

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

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

(in thousands of dollars)	2018
Program services	$ 1,715,760
Management and general	303,527
Fundraising	2,354
	$ 2,021,641

15. Liquidity

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

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

(in thousands of dollars)		2019
Cash and cash equivalents	$	143,587
Patient accounts receivable		221,125
Assets limited as to use		876,249
Other investments for restricted activities		134,119
Total financial assets	$	1,375,080
Less: Those unavailable for general expenditure within one year:		
Investments held by captive insurance companies		66,082
Investments for restricted activities		134,119
Other investments with liquidity horizons greater than one year		97,063
Total financial assets available within one year	$	1,077,816

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

16. Subsequent Events

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

Effective September 30, 2019, the Boards of Trustees of D-HH, GraniteOne Health, Catholic Medical Center Health Services, and their respective member organizations approved a Combination Agreement to combine their healthcare systems. If regulatory approval of the transaction is obtained, the name of the new system will be Dartmouth-Hitchcock Health GraniteOne.

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

On September 13, 2019, the Board of Trustees of D-HH approved the issuance of up to $100,000,000 par of new debt. On October 17, 2019, D-HH closed on the direct placement tax-

exempt borrowing of $99,165,000 on behalf of the DHOG acting through the New Hampshire Health and Education Facilities Authority and issued its DHOG Issue, Series 2019A Bonds.

Consolidating Supplemental Information – Unaudited

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets											
Current assets											
Cash and cash equivalents	$ 42,456	$ 47,465	$ 9,411	$ 7,066	$ 10,462	$ 8,372	$ -	$ 125,232	$ 18,355	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	7,279	6,960	5,010	-	216,067	3,058	-	221,125
Prepaid expenses and other current assets	14,178	139,034	8,583	2,401	5,567	1,423	(74,083)	97,083	1,421	(3,009)	95,495
Total current assets	56,634	367,437	33,854	16,746	24,989	14,805	(74,083)	440,382	22,834	(3,009)	460,207
Assets limited as to use	92,602	688,485	18,759	12,884	12,427	11,619	-	836,576	39,673	-	876,249
Notes receivable, related party	553,484	752	-	1,406	-	-	(554,236)	1,406	(1,406)	-	-
Other investments for restricted activities	-	81,882	6,970	31	2,973	6,323	-	108,179	25,940	-	134,119
Property, plant, and equipment, net	22	432,277	67,147	30,945	41,946	17,797	-	590,134	31,122	-	621,256
Other assets	24,864	108,208	1,279	15,919	6,042	4,388	(10,970)	148,830	(3,013)	(21,346)	124,471
Total assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302
Liabilities and Net Assets											
Current liabilities											
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 954	$ 547	$ 262	$ -	$ 10,819	$ 95	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	3,468	-	-	3,468
Accounts payable and accrued expenses	55,499	99,884	15,620	6,299	3,878	2,776	(74,083)	109,673	6,953	(3,009)	113,617
Accrued compensation and related benefits	-	110,639	5,851	3,694	2,313	4,270	-	126,767	1,841	-	128,408
Estimated third-party settlements	-	26,405	103	1,290	10,851	2,921	-	41,570	-	-	41,570
Total current liabilities	55,499	248,622	22,404	12,237	17,589	10,229	(74,083)	292,497	8,889	(3,009)	298,177
Notes payable, related party	-	526,202	-	-	28,034	-	(554,236)	-	-	-	-
Long-term debt, excluding current portion	643,257	44,820	24,503	35,604	643	11,465	(10,970)	749,322	2,858	-	752,180
Insurance deposits and related liabilities	-	56,786	440	513	388	240	-	58,367	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	-	4,320	-	281,009	-	-	281,009
Other liabilities	-	96,201	1,104	28	1,585	-	-	100,918	23,218	-	124,136
Total liabilities	698,756	1,241,058	58,713	48,382	48,239	26,254	(639,289)	1,482,113	34,805	(3,009)	1,513,909
Commitments and contingencies											
Net assets											
Net assets without donor restrictions	28,832	356,880	63,051	27,653	35,518	21,242	-	533,176	48,063	(21,306)	559,933
Net assets with donor restrictions	18	91,103	6,245	796	4,620	7,436	-	110,218	32,282	(40)	142,460
Total net assets	28,850	447,983	69,296	28,449	40,138	28,678	-	643,394	80,345	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,689,041	$ 128,009	$ 76,831	$ 88,377	$ 54,932	$ (639,289)	$ 2,125,507	$ 115,150	$ (24,355)	$ 2,216,302

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

(In thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 42,456	$ 48,052	$ 11,952	$ 11,120	$ 8,549	$ 15,772	$ 5,886	$ -	$ 143,587
Patient accounts receivable, net	-	180,938	15,880	8,960	5,060	7,280	3,007	-	221,125
Prepaid expenses and other current assets	14,178	139,832	9,460	5,567	1,401	1,678	471	(77,092)	95,495
Total current assets	56,634	368,822	37,292	25,647	15,010	24,730	9,164	(77,092)	460,207
Assets limited as to use	92,602	707,597	17,383	12,427	12,738	12,685	20,817	-	876,249
Notes receivable, related party	553,484	752	-	-	-	-	-	(554,236)	-
Other investments for restricted activities	-	99,807	24,985	2,973	6,323	31	-	-	134,119
Property, plant, and equipment, net	22	434,953	70,846	42,423	19,435	50,338	3,239	-	621,256
Other assets	24,864	108,366	7,388	5,476	1,931	8,688	74	(32,316)	124,471
Total assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 8,226	$ 830	$ 547	$ 288	$ 954	$ 69	$ -	$ 10,914
Current portion of liability for pension and other postretirement plan benefits	-	3,468	-	-	-	-	-	-	3,468
Accounts payable and accrued expenses	55,499	100,441	19,356	3,879	2,856	6,704	2,174	(77,092)	113,817
Accrued compensation and related benefits	-	110,639	5,851	2,313	4,314	4,192	1,099	-	128,408
Estimated third-party settlements	-	26,405	103	10,851	2,921	1,290	-	-	41,570
Total current liabilities	55,499	249,179	26,140	17,590	10,379	13,140	3,342	(77,092)	298,177
Notes payable, related party	-	526,202	-	28,034	-	-	-	(554,236)	-
Long-term debt, excluding current portion	643,257	44,820	24,503	643	11,763	35,604	2,560	(10,970)	752,180
Insurance deposits and related liabilities	-	56,786	440	388	240	513	40	-	58,407
Liability for pension and other postretirement plan benefits, excluding current portion	-	266,427	10,262	-	4,320	-	-	-	281,009
Other liabilities	-	98,201	1,115	1,585	-	23,235	-	-	124,136
Total liabilities	698,756	1,241,615	62,460	48,240	26,702	72,492	5,942	(642,298)	1,513,909
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	28,832	379,498	65,873	36,087	21,300	22,327	27,322	(21,306)	559,933
Net assets with donor restrictions	18	99,184	29,561	4,619	7,435	1,653	30	(40)	142,460
Total net assets	28,850	478,682	95,434	40,706	28,735	23,980	27,352	(21,346)	702,393
Total liabilities and net assets	$ 727,606	$ 1,720,297	$ 157,894	$ 88,946	$ 55,437	$ 96,472	$ 33,294	$ (663,644)	$ 2,216,302

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Assets										
Current assets										
Cash and cash equivalents	$ 134,634	$ 22,544	$ 6,688	$ 9,419	$ 6,604	$ -	$ 179,889	$ 20,280	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,055	-	207,521	11,707	-	219,228
Prepaid expenses and other current assets	11,964	143,893	6,551	5,253	2,313	(72,361)	97,613	4,766	(4,877)	97,502
Total current assets	146,598	343,418	30,422	22,974	13,972	(72,361)	485,023	36,753	(4,877)	516,899
Assets limited as to use	8	616,929	17,438	12,821	10,829	-	658,025	48,099	-	706,124
Notes receivable, related party	554,771	-	-	-	-	(554,771)	-	-	-	-
Other investments for restricted activities	-	87,613	8,591	2,981	6,238	-	105,423	25,473	-	130,896
Property, plant, and equipment, net	36	443,154	66,759	42,438	17,356	-	569,743	37,578	-	607,321
Other assets	24,863	101,078	1,370	5,906	4,260	(10,970)	126,527	3,604	(21,346)	108,785
Total assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025
Liabilities and Net Assets										
Current liabilities										
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 187	$ -	$ 2,600	$ 864	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	3,311	-	-	3,311
Accounts payable and accrued expenses	54,995	82,061	20,107	6,705	3,029	(72,361)	94,536	6,094	(4,877)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,796	-	118,498	7,078	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	-	38,693	2,448	-	41,141
Total current liabilities	57,997	217,299	26,647	19,419	8,637	(72,361)	257,638	16,484	(4,877)	269,245
Notes payable, related party	-	527,348	-	27,425	-	(554,771)	-	-	-	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,270	(10,970)	724,231	28,744	-	752,975
Insurance deposits and related liabilities	-	54,616	465	155	240	-	55,476	40	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	242,227	-	-	242,227
Other liabilities	-	85,577	1,107	1,405	-	-	88,089	38	-	88,127
Total liabilities	702,517	1,170,412	57,788	49,583	25,463	(638,102)	1,367,661	45,306	(4,877)	1,408,090
Commitments and contingencies										
Net assets										
Net assets without donor restrictions	23,759	334,882	61,828	32,897	19,812	-	473,178	72,230	(21,306)	524,102
Net assets with donor restrictions	-	86,898	4,964	4,640	7,400	-	103,902	33,971	(40)	137,833
Total net assets	23,759	421,780	66,792	37,537	27,212	-	577,080	106,201	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,592,192	$ 124,580	$ 87,120	$ 52,675	$ (638,102)	$ 1,944,741	$ 151,507	$ (26,223)	$ 2,070,025

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Assets									
Current assets									
Cash and cash equivalents	$ 134,634	$ 23,094	$ 8,621	$ 9,982	$ 8,654	$ 12,144	$ 5,040	$ -	$ 200,169
Patient accounts receivable, net	-	176,981	17,183	8,302	5,109	7,996	3,657	-	219,228
Prepaid expenses and other current assets	11,964	144,755	5,520	5,276	2,294	4,443	488	(77,238)	97,502
Total current assets	146,598	344,830	31,324	23,560	14,057	24,583	9,185	(77,238)	516,899
Assets limited as to use	8	635,028	17,438	12,821	11,882	9,612	19,355	-	706,124
Notes receivable, related party	554,771	-	-	-	-	-	-	(554,771)	-
Other investments for restricted activities	-	95,772	25,873	2,981	6,238	32	-	-	130,896
Property, plant, and equipment, net	36	445,829	70,807	42,920	19,065	25,725	3,139	-	607,321
Other assets	24,863	101,235	7,526	5,333	1,888	130	128	(32,318)	108,785
Total assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025
Liabilities and Net Assets									
Current liabilities									
Current portion of long-term debt	$ -	$ 1,031	$ 810	$ 572	$ 245	$ 739	$ 67	$ -	$ 3,464
Current portion of liability for pension and other postretirement plan benefits	-	3,311	-	-	-	-	-	-	3,311
Accounts payable and accrued expenses	54,995	82,613	20,052	6,714	3,092	3,596	1,929	(77,238)	95,753
Accrued compensation and related benefits	-	106,485	5,730	2,487	3,831	5,814	1,229	-	125,576
Estimated third-party settlements	3,002	24,411	-	9,655	1,625	2,448	-	-	41,141
Total current liabilities	57,997	217,851	26,592	19,428	8,793	12,597	3,225	(77,238)	269,245
Notes payable, related party	-	527,346	-	27,425	-	-	-	(554,771)	-
Long-term debt, excluding current portion	644,520	52,878	25,354	1,179	11,593	25,792	2,629	(10,970)	752,975
Insurance deposits and related liabilities	-	54,616	465	155	241	-	39	-	55,516
Liability for pension and other postretirement plan benefits, excluding current portion	-	232,696	4,215	-	5,316	-	-	-	242,227
Other liabilities	-	85,577	1,117	1,405	-	28	-	-	88,127
Total liabilities	702,517	1,170,964	57,743	49,592	25,943	38,417	5,893	(642,979)	1,408,090
Commitments and contingencies									
Net assets									
Net assets without donor restrictions	23,759	356,518	65,069	33,383	19,764	21,031	25,884	(21,306)	524,102
Net assets with donor restrictions	-	95,212	29,956	4,640	7,401	634	30	(40)	137,833
Total net assets	23,759	451,730	95,025	38,023	27,165	21,665	25,914	(21,346)	661,935
Total liabilities and net assets	$ 726,276	$ 1,622,694	$ 152,768	$ 87,615	$ 53,108	$ 60,082	$ 31,807	$ (664,325)	$ 2,070,025

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	Alice Peck Day Memorial	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support											
Patient service revenue	$ -	$ 1,580,552	$ 220,255	$ 69,794	$ 60,186	$ 46,029	$ -	$ 1,976,796	$ 22,527	$ -	$ 1,999,323
Contracted revenue	5,011	109,051	355	-	-	5,902	(46,100)	74,219	790	8	75,017
Other operating revenue	21,128	186,852	3,407	1,748	4,261	2,289	(22,076)	197,609	13,386	(297)	210,698
Net assets released from restrictions	369	11,556	732	137	177	24	-	12,995	1,110	-	14,105
Total operating revenue and other support	26,508	1,888,011	224,749	71,679	64,604	54,244	(68,176)	2,261,619	37,813	(289)	2,299,143
Operating expenses											
Salaries	-	868,311	107,671	37,297	30,549	26,514	(24,682)	1,045,660	15,785	1,106	1,062,551
Employee benefits	-	208,346	24,225	8,454	5,434	6,966	(3,783)	247,662	3,642	287	251,591
Medical supplies and medications	-	354,201	34,331	8,634	8,298	3,032	-	408,496	1,379	-	407,875
Purchased services and other	11,366	242,106	35,088	15,308	13,528	13,950	(21,176)	310,170	14,887	(1,822)	323,435
Medicaid enhancement tax	-	54,954	8,005	3,062	2,264	1,776	-	70,081	-	-	70,081
Depreciation and amortization	14	69,343	7,977	2,305	3,915	2,380	-	85,914	2,500	-	88,414
Interest	20,677	21,585	1,053	1,169	1,119	228	(20,850)	24,981	533	-	25,514
Total operating expenses	32,057	1,818,846	218,350	74,229	63,107	54,826	(70,471)	2,190,944	38,726	(229)	2,229,441
Operating (loss) margin	(5,549)	69,165	6,399	(2,550)	1,497	(582)	2,295	70,675	(913)	(60)	69,702
Non-operating gains (losses)											
Investment income (losses), net	3,929	32,193	227	469	834	823	(198)	38,077	1,975	-	40,052
Other (losses) income, net	(3,784)	1,586	(187)	30	(240)	279	(2,097)	(4,413)	791	80	(3,562)
Loss on early extinguishment of debt	-	-	-	(87)	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-	-	-
Total non-operating gains (losses), net	145	33,779	40	412	594	902	(2,295)	33,577	2,766	80	36,403
(Deficiency) excess of revenue over expenses	(5,404)	102,944	6,439	(2,138)	2,091	320	-	104,252	1,853	-	106,105
Net assets without donor restrictions											
Net assets released from restrictions	-	419	585	-	402	318	-	1,704	85	-	1,789
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	-	682	-	(72,043)	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,939	8,760	128	110	-	5,054	(5,054)	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 21,998	$ 1,223	$ 6,622	$ 2,621	$ 1,430	$ -	$ 38,967	$ (3,136)	$ -	$ 35,831

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD and Subsidiaries	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,580,552	$ 220,254	$ 60,166	$ 46,029	$ 69,794	$ 22,528	$ -	$ 1,999,323
Contracted revenue	5,010	109,842	355	-	5,902	-	-	(46,092)	75,017
Other operating revenue	21,128	188,775	3,549	4,260	3,868	10,951	540	(22,373)	210,698
Net assets released from restrictions	371	12,637	732	177	26	162	-	-	14,105
Total operating revenue and other support	26,509	1,891,806	224,890	64,603	55,825	80,907	23,068	(68,465)	2,299,143
Operating expenses									
Salaries	-	868,311	107,706	30,549	27,319	40,731	11,511	(23,576)	1,062,551
Employee benefits	-	208,346	24,235	5,434	7,133	7,218	2,701	(3,476)	251,591
Medical supplies and medications	-	354,201	34,331	6,298	3,035	8,639	1,371	-	407,875
Purchased services and other	11,368	246,101	35,396	13,390	14,371	18,172	7,437	(22,798)	323,435
Medicaid enhancement tax	-	54,954	8,005	2,264	1,776	3,062	-	-	70,061
Depreciation and amortization	14	69,343	8,125	3,920	2,478	4,194	340	-	88,414
Interest	20,678	21,585	1,054	1,119	228	1,637	63	(20,850)	25,514
Total operating expenses	32,058	1,822,841	218,852	62,974	56,340	83,653	23,423	(70,700)	2,229,441
Operating (loss) margin	(5,549)	68,965	6,038	1,629	(515)	(2,746)	(355)	2,235	69,702
Non-operating gains (losses)									
Investment income (losses), net	3,929	33,310	129	765	645	469	983	(198)	40,052
Other (losses) income, net	(3,784)	1,586	(171)	(240)	288	31	765	(2,037)	(3,562)
Loss on early extinguishment of debt	-	-	-	-	-	(87)	-	-	(87)
Loss on swap termination	-	-	-	-	-	-	-	-	-
Total non-operating gains (losses), net	145	34,896	(42)	545	933	413	1,748	(2,235)	36,403
(Deficiency) excess of revenue over expenses	(5,404)	103,861	5,996	2,174	418	(2,333)	1,393	-	106,105
Net assets without donor restrictions									
Net assets released from restrictions	-	484	565	402	318	-	-	-	1,769
Change in funded status of pension and other postretirement benefits	-	(65,005)	(7,720)	-	682	-	-	-	(72,043)
Net assets transferred to (from) affiliates	10,477	(16,360)	1,963	128	116	3,629	45	-	-
Additional paid in capital	-	-	-	-	-	-	-	-	-
Other changes in net assets	-	-	-	-	-	-	-	-	-
Change in fair value on interest rate swaps	-	-	-	-	-	-	-	-	-
Change in funded status of interest rate swaps	-	-	-	-	-	-	-	-	-
Increase in net assets without donor restrictions	$ 5,073	$ 22,980	$ 804	$ 2,704	$ 1,536	$ 1,296	$ 1,438	$ -	$ 35,831

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

(in thousands of dollars)	Dartmouth-Hitchcock Health	Dartmouth-Hitchcock	Cheshire Medical Center	New London Hospital Association	Mt. Ascutney Hospital and Health Center	Eliminations	DH Obligated Group Subtotal	All Other Non-Oblig Group Affiliates	Eliminations	Health System Consolidated
Operating revenue and other support										
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,486	$ 52,014	$ -	$ 1,804,550	$ 94,545	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	-	45,319	2,048	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	-	1,759,231	92,497	-	1,851,728
Contracted revenue	(2,305)	97,291	-	-	2,169	(42,870)	54,285	716	(32)	54,969
Other operating revenue	9,799	134,461	3,365	4,169	1,814	(10,554)	143,054	6,978	(1,086)	148,946
Net assets released from restrictions	658	11,605	620	52	44	-	12,979	482	-	13,461
Total operating revenue and other support	8,152	1,687,313	209,754	63,153	54,601	(53,424)	1,969,549	100,673	(1,118)	2,069,104
Operating expenses										
Salaries	-	806,344	105,607	30,360	24,854	(21,542)	945,623	42,035	1,605	989,263
Employee benefits	-	181,833	28,343	7,252	7,000	(5,385)	219,043	10,221	419	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,055	-	329,836	10,195	-	340,031
Purchased services and other	8,509	215,073	33,065	13,587	13,960	(19,394)	264,800	29,380	(2,818)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,658	1,744	-	65,517	2,175	-	67,692
Depreciation and amortization	23	66,073	10,217	3,934	2,030	-	82,277	2,501	-	84,778
Interest	8,684	15,772	1,004	961	224	(8,882)	17,783	1,039	-	18,822
Total operating expenses	17,216	1,627,466	217,599	64,934	52,867	(55,203)	1,924,879	97,556	(794)	2,021,841
Operating margin (loss)	(9,064)	59,847	(7,845)	(1,781)	1,734	1,779	44,670	3,117	(324)	47,463
Non-operating gains (losses)										
Investment income (losses), net	(26)	33,628	1,408	1,151	658	(198)	36,821	3,566	-	40,387
Other (losses) income, net	(1,364)	(2,599)	-	1,276	266	(1,581)	(4,002)	733	361	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	(14,214)	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	(14,247)	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	2,873	1,408	2,122	1,124	(1,779)	4,358	4,299	361	9,018
(Deficiency) excess of revenue over expenses	(10,454)	62,720	(6,437)	341	2,858	-	49,028	7,416	37	56,481
Net assets without donor restrictions										
Net assets released from restrictions	-	16,038	-	4	252	-	16,294	19	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	8,254	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-	-
Additional paid in capital	-	-	-	-	-	-	-	58	(58)	-
Other changes in net assets	-	-	-	-	-	-	-	(185)	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	4,190	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	14,102	-	-	14,102
Increase in net assets without donor restrictions	$ 7,337	$ 75,995	$ 3,578	$ 393	$ 4,565	$ -	$ 91,868	$ 7,308	$ (21)	$ 99,155

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

(in thousands of dollars)	D-HH and Other Subsidiaries	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	APD	VNH and Subsidiaries	Eliminations	Health System Consolidated
Operating revenue and other support									
Patient service revenue	$ -	$ 1,475,314	$ 216,736	$ 60,488	$ 52,014	$ 71,458	$ 23,087	$ -	$ 1,899,095
Provision for bad debts	-	31,358	10,967	1,554	1,440	1,680	368	-	47,367
Net patient service revenue	-	1,443,956	205,769	58,932	50,574	69,778	22,719	-	1,851,728
Contracted revenue	(2,305)	98,007	-	-	2,169	-	-	(42,902)	54,969
Other operating revenue	9,799	137,242	4,061	4,166	3,168	1,697	453	(11,640)	148,946
Net assets released from restrictions	658	11,984	620	52	44	103	-	-	13,461
Total operating revenue and other support	8,152	1,691,189	210,450	63,150	55,955	71,578	23,172	(54,542)	2,069,104
Operating expenses									
Salaries	-	806,344	105,607	30,360	25,592	29,215	12,082	(19,937)	989,263
Employee benefits	-	181,833	28,343	7,252	7,162	7,406	2,653	(4,966)	229,683
Medical supplies and medications	-	289,327	31,293	6,161	3,057	8,484	1,709	-	340,031
Purchased services and other	8,512	218,690	33,431	13,432	14,354	19,220	5,945	(22,212)	291,372
Medicaid enhancement tax	-	53,044	8,070	2,659	1,743	2,176	-	-	67,692
Depreciation and amortization	23	66,073	10,357	3,939	2,145	1,831	410	-	84,778
Interest	8,684	15,772	1,004	981	223	975	65	(8,882)	18,822
Total operating expenses	17,219	1,631,083	218,105	64,784	54,276	69,307	22,864	(55,997)	2,021,641
Operating (loss) margin	(9,067)	60,106	(7,655)	(1,634)	1,679	2,271	308	1,455	47,463
Non-operating gains (losses)									
Investment income (losses), net	(26)	35,177	1,954	1,097	787	203	1,393	(198)	40,387
Other (losses) income, net	(1,364)	(2,599)	(3)	1,276	273	(223)	952	(1,220)	(2,908)
Loss on early extinguishment of debt	-	(13,909)	-	(305)	-	-	-	-	(14,214)
Loss on swap termination	-	(14,247)	-	-	-	-	-	-	(14,247)
Total non-operating gains (losses), net	(1,390)	4,422	1,951	2,068	1,060	(20)	2,345	(1,418)	9,018
(Deficiency) excess of revenue over expenses	(10,457)	64,528	(5,704)	434	2,739	2,251	2,653	37	56,481
Net assets without donor restrictions									
Net assets released from restrictions	-	16,058	-	4	251	-	-	-	16,313
Change in funded status of pension and other postretirement benefits	-	4,300	2,827	-	1,127	-	-	-	8,254
Net assets transferred to (from) affiliates	17,791	(25,355)	7,188	48	328	-	-	-	-
Additional paid in capital	58	-	-	-	-	-	-	(58)	-
Other changes in net assets	-	-	-	-	-	(185)	-	-	(185)
Change in fair value on interest rate swaps	-	4,190	-	-	-	-	-	-	4,190
Change in funded status of interest rate swaps	-	14,102	-	-	-	-	-	-	14,102
Increase (decrease) in net assets without donor restrictions	$ 7,392	$ 77,823	$ 4,311	$ 486	$ 4,445	$ 2,066	$ 2,653	$ (21)	$ 99,155

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

1. Basis of Presentation

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

APDMH Board of Trustees

Members				Staff	
1	Chair	Greg Lange	Trustee	Kim Carboneau	HR Director
2	Vice Chair	Marisa Devlin	Trustee	Peter Glenshaw	Vice President, External Affairs
3	Secretary	Mike Long	Trustee	Cindy Jerome	Lifecare Executive Director
4	Treasurer	Brett Peltzer	Trustee	Tracy Mayer	Executive Office Manager
5	President & CEO	Sue Mooney	Ex officio with vote	Todd Roberts	Financial Lead
6	D-HH CEO Designee	Mary Oseid	Ex officio with vote	Jean Ten Haken	COO/CNO
7	APD Medical Staff President	John Houde	Ex officio with vote	Dale Vidal	Executive Director, MSC
8	APD Chief Medical Officer	Michael Lynch	Ex officio without vote		
9	Lifecare BoT Chair	Sara Kobylenski	Ex officio with vote*	*Limited to votes pertaining to Lifecare	
10	Appointed Trustee	Clay Adams	Trustee		
11	D-HH Designee	George Blike	Trustee		
12	Appointed Trustee	Kyle Fisher	Trustee		
13	Appointed Trustee	Rebecca Holcombe	Trustee		
14	D-HH Designee	Pat Jordan	Trustee		
15	D-HH Designee	Tina Naimie	Trustee		
16	Appointed Trustee	Ben Riehl	Trustee		
17	D-HH Designee	Scott Rodi	Trustee		
18	Appointed Trustee	John Scherding	Trustee		
19	Appointed Trustee	Jen Schiffman	Trustee		
20	Appointed Trustee	Charlie Wheelan	Trustee		
21	D-HH Designee	Available	Trustee		

ALICE PECK DAY MEMORIAL HOSPITAL

Michael Lynch, MD, MBA
lynchm@apdmh.org
(603) 448-7440

PROFESSIONAL EXPERIENCE

ALICE PECK DAY MEMORIAL HOSPITAL, A DARTMOUTH-HITCHCOCK AFFILIATE, Lebanon, NH, June 2019 – present

Alice Peck Day is a community hospital that serves Lebanon and surrounding communities. There is a multispecialty medical office on the grounds of the hospital. There is an orthopedic and neurosurgical focus on the surgical side and strong primary care practice for pediatrics, internal medicine and family practice that serves the Upper Connecticut Valley.

Chief Medical Officer

- Member of the Senior Leadership Team
- In charge of rewriting Bylaws and Rules and Regulations
- Provides oversight of Quality Assurance and Peer Review
- In charge of implementing integration with Dartmouth-Hitchcock Health including shared EMR (Epic) and Hospitalist and ED physician integration and expansion of orthopedic surgery program with Dartmouth orthopedists

Clinical work as Emergency Physician, Alice Peck Day Memorial Hospital and per diem emergency physician, New London Hospital, New London, NH June 2019 – present.

Clinical work as Emergency Physician and Clinical Instructor, The Geisel School of Medicine, Dartmouth Hitchcock Medical Center, Lebanon, NH September 2019 – present.

Clinical Work as Emergency Physician per diem, Concord Hospital, Concord, NH April – May 2019.

RELIANT MEDICAL GROUP, Worcester, MA, October 2018 – April 2019

The Reliant Medical Group, formally the Fallon Clinic is a 500-provider multispecialty group providing regional medical care in the greater Worcester and Metrowest area of Boston. It is a largely capitated reimbursement model. It is the lowest cost provider group in Massachusetts.

Executive Medical Director of Same Day Services

- Worked with primary care physicians to increase collaboration and decrease ED utilization and hospital admissions and decreasing the total medical expense per patient.
- Provided management oversight of high complexity urgent care, ReadyMed Plus, which has an annual volume of 48,000 and includes a pediatric side, an adult side and an

infusion center. This site also includes high complexity, on-site labs and imaging including x-ray and cat scan.

- Total Annual Volume for Same Day Services is 147,000
- Provided management oversight for three other regional urgent cares.
- Managed 40 providers and 100 employees at the 4 sites. The infusion Center and Occupational Health with 39,000 visits reports through me.
- Managed provider compensation models, salary negotiations and QA measures.
- Managed provider annual reviews
- Implemented flow improvements, standardized treatment and diagnostic protocols.
- Worked with executive team on strategic planning.
- Clinical practice in the high acuity urgent care October 2018 – April 2019.

CONCORD HOSPITAL, CONCORD, NH, 1997-2018

Concord Hospital is a busy community ED that has grown from a volume of 35,000 in 1997 to an ED volume of 47,000 plus today with an Urgent Care with a volume of 17,000. It is a Level 2 Trauma Center and has interventional cardiology and is Stroke Certified.

CHAIR OF EMERGENCY MEDICINE (2003-2005 and 2013-2018)

- Worked with hospital leadership to align department goals with institutional strategic plan.
- Worked closely with nursing director and nursing team on daily operations, treatment protocols and strategy.
- Led ED Patient Flow Process Improvement that lead to over 105 minute (33%) decreased length of stay for patients discharged to home.
- Led a CT TAT Process Improvement that resulted in a 20-minute reduction in time from order to final reading.
- Led Urgent Care Patient Flow Improvement to reduce variability, standardize care and reduce length of stay from 1.9 hours to 1 hour in a moderate complexity urgent care.
- Initiated and led care management process to improve coordination and reduce ED utilization in high utilizer group by 60%.
- Led process improvement in patient satisfaction scores moving the scores from 85th to 95-99th Percentile for physicians. The efforts were based on scripting, open-ended questions, and white boards to give patients a visual understanding of their care.
- Helped to lead the ED transition for a system-wide Cerner EHR on Dec. 1, 2017.
- Led initiation and implementation of ED bedside ultrasound implementation and QA.

MEDICAL DIRECTOR OF URGENT CARE (2013-2018),
Concord Hospital Walk-In Urgent Care

The Medical Director functions within the role of the Chair of Emergency Medicine as an operational role to develop treatment protocols and to coordinate care with the ED and primary care practices to streamline care.

CONCORD EMERGENCY MEDICAL ASSOCIATES, CONCORD HOSPITAL,

CONCORD, NH 1997-2018

PRESIDENT (2005-2009)
The President of Concord Emergency Medical Associates is responsible for hiring for the organization, reviewing and creating the budget with the business manager, and over site of coding and billing and contractual negotiations.

- Helped to lead the group in revenue and volume growth over the 4 years.
- Cultivated growth of patient volume from 35,000 to 60,000 visits and seven physicians and five physician assistants to fifteen physicians and eleven physician assistants.
- Led the ED group through 1997 CPT coding transition and ICD-10 transition to improve the quality of documentation and reimbursement.

VICE PRESIDENT (2000-2005)
The Vice President role is supportive of the President of the group with the associated business and group management responsibilities. In addition, it involved weekly oversight and review of documentation and coding and assistance with negotiations and strategy and personnel management.

EMERGENCY PHYSICIAN (1997-2018)

EMERGENCY PHYSICIAN, SOUTH SHORE HOSPITAL, WEYMOUTH, MA, 1996-1997.

South Shore hospital is a large community hospital in the Boston suburbs and had an ED volume of 60,000 in 1997.

MULTISYSTEM AND STATE LEVEL COMMITTEE WORK

Chair of Granite Health Network ED Patient Flow Improvement, Concord, NH

- A five-hospital affiliation in southern NH. This group creates metrics and common goals for innovation and best practices that are reported to the CEOs of the five hospitals.

Governor's Task Force to address Mental Health Crisis in the State of NH, May 2017-Spring of 2018.

- This group met with the governor and the Head of NH Health and Human Services Department and included community mental health center directors, and community mental health advocates.

BOARD SERVICE

Concord Hospital Trust Board Member, 2007 to 2018, Chair 2017-18.

- Served on inaugural board in 2007; as Secretary, 2013-14; Chair Elect, 2015-16; Chair, 2017-18. The Concord Hospital Trust exists to support the chartable mission of Conocrd Hospital and the community it serves. The Trust has raised over $31 million since its inception.

Concord Regional Health Care, Board Member, January 2017 to 2018.

- A hospital corporation oversight board that coordinates care delivery between Concord Hospital, the Concord Regional VNA, and Riverbend Community Mental Health Center. The board's current focus is implementation of the Integrated Delivery Network and the 1115 Medicaid Waiver to oversee approximately $18 million over ten years to delivery systems to provide resources for combating the opioid crisis and strengthening the state's strained mental health system.

Concord Hospital Medical Executive Committee, 2003-2005 and 2013-2018.

- Maintaining the governance of a diverse medical staff that includes providers from several independent groups, a large academic affiliated clinic, and employed hospital providers.

EDUCATION

Brandeis University, Heller School for Social Policy and Management, Physician Executive MBA, 2017

Residency in Emergency Medicine: Hennepin County Medical Center
Minneapolis, MN 1996

University of Virginia School of Medicine 1993
Society of Academic Emergency Medicine Award

Dartmouth College, BA 1987,
English Honors, Graduated Cum Laude

Southern New Hampshire University, Masters Healthcare Administration Courses
Coursework in: Healthcare Policy and Finance; Healthcare Informatics; Services Marketing, 2014.

LEADERSHIP TRAINING AND PROFESSIONAL DEVELOPMENT

- Shingo Learning Group, 2016-present (Selected by COO to study and lead change at Concord Hospital with other physician leaders.) This group of hospital and physician leaders is committed to developing a lean culture and visual management systems.
- Managing Organizational Transition, Bridges and Associations, 2016
- NH Assoc. of Medical Staff Services, Horty Springer Leadership Retreat, 2014.
- Lean Training at Virginia Mason Institute, Seattle, Washington, 2014.
- Crucial Conversations, Organizational Development, Concord Hospital, 2014.
- LEAN training at Concord Hospital, 2013.
- Power and Positive Influence Class, Organizational Development, 2013.
- American College of Emergency Physicians Emergency Department Directors Academy, Phases 1, 2 and 3, Dallas, TX. Phase 4 project completed Nov., 2013.

EMR

- Trained in Epic and Cerner

PUBLICATIONS

Lynch, MT, Six Things I Wish I'd Known When I Finished Residency, *Emergency Physicians Monthly,* November, 2015.

Hick J, Smith S, Lynch MT. Metabolic Acidosis Restraint Associated Cardiac Arrest: A Case Series. *Academic Emergency Medicine. 1999.*

Lynch MT, Syverud SA, Schwab RA, Jenkins JM, Edlich R. Comparison of Intraoral and Percutaneous Approaches for Infraorbital Nerve Block. *Academic Emergency Medicine. 1994*

Lynch MT, Bellian KT, Edlich RF, Himel HN. Model Rocket Burn Injuries: the Need for Stricter Regulation. *The Journal of Emergency Medicine. 1994*

PRESENTATIONS

Concord Hospital Trauma Conference, "Cases That Fooled Me – How We Think and Create High Quality Healthcare – Checklists, Heuristics and Bias Awareness", June, 2018

Concord Hospital Trust Medical Staff Dinner – The Mission of the Trust in Support of the Charitable Mission, November 2017

AWARDS

- *NH Magazine* Top Doctors 2007, 2008, 2009, 2010.
- Society for Academic Emergency Medicine, Emergency Medicine Award University of Virginia, 1993

COMMUNITY SERVICE

- Concord American Little League, Board Member and Safety Officer, 2013-2014.
- Red River Theater, Fundraiser, 2003.
- Concord Area United Way Annual Fund committee, 2001.

PROFESSIONAL SOCIETIES

- American College of Emergency Physicians
- Fellow American College of Emergency Physicians (FACEP)
- New Hampshire College of Emergency Physicians
- Massachusetts Medical Society

PERSONAL PROFILE

I am married to my wife of thirty-one years. She is Dean of Academic Programs and an English teacher at the Derryfield School. We have four children, ages 27, 25, 20 and 16.

CONTRACTOR NAME

Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Michael Lynch	Chief Medical Officer	n/a	0	0