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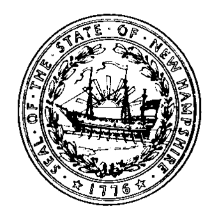

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH

Jeffrey A. Meyers
Commissioner

Katja S. Fox
Director

129 PLEASANT STREET, CONCORD, NH 03301
603-271-9422 1-800-852-3345 Ext. 9422
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April 7, 2016

Her Excellency, Governor Margaret Wood Hassan
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Health and Human Services Bureau of Behavioral Health to enter into an agreement with Mary Hitchcock Memorial Hospital (Vendor #177160), One Medical Center Drive, Lebanon, NH 03756 to provide a training program for the Community Mental Health Centers which will enable delivery of evidence-based Coordinated Specialty Care services for First Episode Psychosis patients, in an amount not to exceed $90,161, effective upon Governor and Executive Council approval through September 30, 2016. 100% Federal Funds.

Funds to support this request are available in State Fiscal Year 2016 and State Fiscal Year 2017 upon availability and continued appropriation of funds in the future operating budget, with the ability to adjust encumbrances between State Fiscal Years through the Budget Office without Governor and Executive Council approval, if needed and justified.

05-95-92-920010-7143 HEALTH AND SOCIAL SERVICES, DEPT OF HEALTH AND HUMAN SERVICES, HHS: BUREAU OF BEHAVIORAL HEALTH

STATE FISCAL YEAR	CLASS	TITLE	ACTIVITY CODE	AMOUNT
2016	102	Contracts for Program Scvs	92207143	$80,209
2017	102	Contracts for Program Scvs	92207143	$9,952
			Total:	**$90,161**

EXPLANATION

The purpose of this agreement is to provide training services to the Community Mental Health Centers, which will enable delivery of evidence-based Coordinated Specialty Care services for First Episode Psychosis patients. First Episode Psychosis is a comprehensive approach to treatment for individuals with first or early stage manifestation of a psychotic disorder. Early intervention services for First Episode Psychosis can improve symptoms and restore functioning in a manner superior to standard care services.

The Vendor will develop and implement a training program for Community Mental Health Centers, statewide, in fidelity with evidence based First Episode Psychosis training models. A statewide training program ensures a team-based approach to specialized early intervention programs. The approach emphasizes prompt detection; acute care during periods of crisis; and recovery-oriented services offered over a two to three year period.

Treatment services include Coordinated Specialty Care, which involves several professionals with varying levels and areas of expertise who provide evidence based treatments effective in improving clinical and functional outcomes among youth and young adults at risk for serious mental illness.

This contract was competitively bid. On November 25, 2015 the Department of Health and Human Services issued a Request for Proposals for a trainer for First Episode Psychosis (FEP) Treatment Services. The request for proposals was available on the Department of Health and Human Services website from November 25, 2015 through January 8, 2016. There was one proposal submitted.

The proposal was evaluated based on the criteria published in the Request for Proposals by a team of individuals with program specific knowledge and expertise. Mary Hitchcock Memorial Hospital was selected. The bid summary is attached.

This contract contains language which allows for the option to renew the contract for up to two (2) additional years, subject to the continued availability of funds, satisfactory performance and approval by Governor and Executive Council.

The Vendor will design, develop, coordinate and administer training programs and curricula to Community Mental Health Centers, statewide, which include collaborative work between the Department and the Community Mental Health Centers to ensure all parties have the most recent training curricula available. The Vendor will provide and maintain all necessary supplies and equipment for training session and will be responsible for securing the training venues, marketing training opportunities, and conducting registration functions at training location. The Vendor will also explore the needs of on-line delivery for appropriate curricula on a continuous basis and will provide an analysis of such delivery to the Department in its final report.

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

Area served: Statewide

Source of Funds: 100% Federal Funds, 0% General Funds

In the event that the federal funds become no longer available, no further general funds will be requested to support this contract.

Respectfully submitted

Katja S. Fox
Director

Approved by: Jeffrey A. Meyers
Commissioner

New Hampshire Department of Health and Human Services
Office of Business Operations
Contracts & Procurement Unit
Summary Scoring Sheet

Trainer for First Episode Psychosis (FEP) Treatment Services
RFP Name

RFP #16-DHHS-DCBCS-BBH-07
RFP Number

Bidder Name	Pass/Fail	Maximum Points	Actual Points
1. Mary Hitchcock Memorial Hospital, Dartmouth-Hitchcock		195	153
2. 0		195	0
3. 0		195	0
4. 0		195	0
5. 0		195	0

Reviewer Names

1. Beth Anne Nichols, Mental Health Block Grant State Planner
2. David LaCroix, Peer Support Specialist, NHH Rehabilitation Dept
3. Molly Gray, Consumer Advocate
4. Elizabeth Fenner-Lukaitis, Acute Care Services Coordinator, DHHS
5. Donna Walker, Mental Health, Finance/Audit Administrator III
6. P.J. Nadeau, OBO, Audit-Finance Administrator
7. Jim Dall, Director Prog Support, DHHS Medicaid Administration

FORM NUMBER P-37 (version 5/8/15)

Subject: Trainer for First Episode Psychosis (FEP) Treatment Services

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

AGREEMENT

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

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name Department of Health & Human Services		1.2 State Agency Address 129 Pleasant Street Concord, NH 03301	
1.3 Contractor Name Mary Hitchcock Memorial Hospital		1.4 Contractor Address One Medical Center Drive Lebanon, NH 03756	
1.5 Contractor Phone Number (603) 650-5606	1.6 Account Number 05-95-92920010-7143-102-0731	1.7 Completion Date September 30, 2016	1.8 Price Limitation $90,161
1.9 Contracting Officer for State Agency Eric D. Borrin, Director		1.10 State Agency Telephone Number (603) 271-9558	
1.11 Contractor Signature [signature] MD		1.12 Name and Title of Contractor Signatory Robert A. Greene EVP, Population Health Management	
1.13 Acknowledgement: State of New Hampshire County of Grafton On 3/28/16, before the undersigned officer, personally appeared the person identified in block 1.12, or satisfactorily proven to be the person whose name is signed in block 1.11, and acknowledged that s/he executed this document in the capacity indicated in block 1.12.			
1.13.1 Signature of Notary Public or Justice of the Peace [signature] [Seal]			
1.13.2 Name and Title of Notary or Justice of the Peace Laura K. Rogers Notary Public			
1.14 State Agency Signature [signature] Date: 4/7/16		1.15 Name and Title of State Agency Signatory Katja S Fix, Director, DBH	
1.16 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.17 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: [signature] Megan A. Yaple - Attorney		On: 4/18/16	
1.18 Approval by the Governor and Executive Council *(if applicable)* By:		On:	

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

3. EFFECTIVE DATE/COMPLETION OF SERVICES.
3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.18, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.14 ("Effective Date").
3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.
Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds, and in no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to terminate this Agreement immediately upon giving the Contractor notice of such termination. The State shall not be required to transfer funds from any other account to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

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

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.
6.1 In connection with the performance of the Services, the Contractor shall comply with all statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal opportunity laws. This may include the requirement to utilize auxiliary aids and services to ensure that persons with communication disabilities, including vision, hearing and speech, can communicate with, receive information from, and convey information to the Contractor. In addition, the Contractor shall comply with all applicable copyright laws.
6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.
6.3 If this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all the provisions of Executive Order No. 11246 ("Equal Employment Opportunity"), as supplemented by the regulations of the United States Department of Labor (41 C.F.R. Part 60), and with any rules, regulations and guidelines as the State of New Hampshire or the United States issue to implement these regulations. The Contractor further agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.
7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.
7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this

Contractor Initials [handwritten initials]
Date 3/22/16

Agreement. This provision shall survive termination of this Agreement.
7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.
8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):
8.1.1 failure to perform the Services satisfactorily or on schedule;
8.1.2 failure to submit any report required hereunder; and/or
8.1.3 failure to perform any other covenant, term or condition of this Agreement.
8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:
8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely remedied, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;
8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;
8.2.3 set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or
8.2.4 treat the Agreement as breached and pursue any of its remedies at law or in equity, or both.

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

10. TERMINATION. In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT A.

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

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS. The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice and consent of the State. None of the Services shall be subcontracted by the Contractor without the prior written notice and consent of the State.

13. INDEMNIFICATION. The Contractor shall defend, indemnify and hold harmless the State, its officers and employees, from and against any and all losses suffered by the State, its officers and employees, and any and all claims, liabilities or penalties asserted against the State, its officers and employees, by or on behalf of any person, on account of, based or resulting from, arising out of (or which may be claimed to arise out of) the acts or omissions of the Contractor. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 comprehensive general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000per occurrence and $2,000,000 aggregate ; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 9.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

Contractor Initials LM
Date 3/22/16

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than thirty (30) days prior to the expiration date of each of the insurance policies. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference. Each certificate(s) of insurance shall contain a clause requiring the insurer to provide the Contracting Officer identified in block 1.9, or his or her successor, no less than thirty (30) days prior written notice of cancellation or modification of the policy.

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

16. WAIVER OF BREACH. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

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

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

19. CONSTRUCTION OF AGREEMENT AND TERMS. This Agreement shall be construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party.

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

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

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

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

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire Agreement and understanding between the parties, and supersedes all prior Agreements and understandings relating hereto.

Contractor Initials AAL
Date 3/22/11

Scope of Services

1. Provisions Applicable to All Services

1.1. The Contractor will submit a detailed description of the language assistance services they will provide to persons with limited English proficiency to ensure meaningful access to their programs and/or services within ten (10) days of the contract effective date.

1.2. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.

2. Scope of Services

2.1. The Contractor shall provide training to Community Mental Health Centers, statewide, on First Episode Psychosis Treatment Services used to treat individuals ages fifteen (15) to thirty-five (35) who present with symptoms of a psychotic disorder and meet State eligibility criteria for either a:

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

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

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

2.2.1. Initial Assessments.

2.2.2. Clinical and Support Skills.

2.2.3. Coordination of FEP treatment.

2.3. The Contractor shall train Community Mental Health Center (CMHC) staff in the FEP NAVIGATE Model, which includes but is not limited to:

2.3.1. Training all team FEP team members in fundamental information about FEP.

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

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

2.3.3.1. Motivational interviewing strategies.

2.3.3.2. Cognitive-behavioral strategies.

2.3.3.3. Strategies for involving family members and other supporters.

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

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

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

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

2.3.4.4. Identify the key needs of individuals with firs or early psychosis.

2.3.4.5. Contribute to the weekly FEP NAVIGATE team meetings.

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

2.4. The Contractor shall ensure CMHCs FEP teams include, but are not limited to:

2.4.1. A Program Director who is trained to:

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

2.4.1.2. Recruit individuals who have begun to experience psychosis.

2.4.1.3. Lead the FEP team.

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

2.4.2.1. Assist natural supports in learning:

2.4.2.1.1. General information about psychosis

2.4.2.1.2. How to manage psychosis.

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

2.4.2.2. Conduct outreach and recruitment to community agencies.

2.4.2.3. Evaluate potential clients for the NAVIGATE program.

2.4.2.4. Use engagement strategies to involve clients in treatment.

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

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

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

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

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

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

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

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

2.4.3.1. Use low doses of medications to treat FEP.

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

2.4.3.2.1. Avoiding authoritarian approaches.

2.4.3.2.2. Using strategies for accommodating client ambivalence

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

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

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

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

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

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

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

2.4.4.1. Assist individuals identify and work towards their goals

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

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

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

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

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

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

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

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

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

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

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

2.4.5.4. Collaborative complete a Career Inventory.

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

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

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

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

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

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

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

2.4.7.1. Assist clients by sharing experiences of recovery.

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

2.4.7.2.1. Working.

2.4.7.2.2. Attending school.

2.4.7.2.3. Fostering positive relationships.

2.4.7.2.4. Developing a strong support system.

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

2.5.1. Phase 1- Readiness Assessment and Preparation. The Contractor shall complete an assessment of and provide support for the Community Mental Health Center to ensure the agency is prepared to implement the NAVIGATE program. Phase 1 activities include, but are not limited to:

2.5.1.1. Telephone consultations with the Community Mental Health Center in order to assess readiness for receiving training. The Contractor shall ensure consultations are conducted in the presence of the CMHC administrative and clinical leadership and topics include, but are not limited to:

2.5.1.1.1. Discussion of the facility and its services, including but not limited to, any current early psychosis efforts; characteristics of the current population served; and plans for implementing FEP NAVIGATE.

2.5.1.1.2. Overview of Phase 2 and Phase 3 format requirements.

2.5.1.1.3. Identification and formal 'buy-in' of local FEP leadership team and stakeholders.

2.5.1.1.4. Identification of proposed FEP team members, with special attention to scope of practice; need for any additional training; optimal case size; and plans for release from current duties.

2.5.1.1.5. Review of resources needed to implement the NAVIGATE program, with development of plans to access any resources currently not available at the agency.

2.5.1.1.6. Development of funding streams and strategies.

2.5.1.1.7. Discussion of plans for the prescriber regarding the time that shall be dedicated to regular meetings with clients, weekly team meetings and monthly consultation calls.

2.5.1.1.8. Responses to administrative or clinical leadership questions regarding NAVIGATE.

2.5.1.2. Telephone consultations with Community Mental Health Centers that will prepare the agency to implement FEP NAVIGATE, on topics that include but are not limited to:

2.5.1.2.1. Strategies for program development.

2.5.1.2.2. Strategies for setting up the team.

2.5.1.2.3. Establishment of enrollment criteria.

2.5.1.2.4. Methods of working with private insurance and public assistance.

2.5.1.2.5. Development of a referral network.

2.5.1.2.6. Specific time that shall be set aside for staff to participate in team meetings and consultation calls.

2.5.1.2.7. Identification of outcome measures.

2.5.1.2.8. Establishment of materials and routines for outreach, referrals and engagement.

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

2.5.2.1. Providing two full days of in-person training for the IRT, Director/Family; and SEE, otherwise known as the psychosocial team members.

2.5.2.2. Ensuring a minimum of five (5) hours of training is available and dedicated to the prescriber, of which:

2.5.2.2.1. Two (2) hours shall be on prescriber-specific training.

2.5.2.2.2. Three (3) hours shall be on team training.

2.5.2.3. Providing an additional full day of additional on-site training after the two (2) day training is complete. The additional day of training shall be specific to the SEE and focus on:

2.5.2.3.1. Engaging with the community to create relationships with local employers in order to complete job development for clients.

2.5.2.3.2. Developing and reviewing SEE record-keeping to promote fidelity measures that provide valuable information to funders, trainers/supervisors and clients/natural supports.

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

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

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

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

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

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

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

2.5.3.7. Review regular summaries of weekly team meetings conducted by the Director to ensure Director Fidelity.

2.5.3.8. Ensure SEE Fidelity through review of:

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

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

2.5.3.8.3. Case presentations.

2.5.3.9. Conduct a minimum of one (1) full day on-site observation of the SEE in the clinic and in the community.

2.6. The Contractor shall ensure FEP NAVIGATE trainees in the Community Mental Health Centers receive reference materials that supplement the trainings provided, including but not limited to:

2.6.1. Copies of the NAVIGATE Team Members' Guide for all team members.

2.6.2. Copies of the Director's Manuals, Family Education Manual, IRT manual, SEE manual and Prescriber's Manual, and links to Recovery Videos featuring clients and family members, for each Director receiving training.

2.6.3. Copies of the IRT Manual and links to the IRT videos for all IRT clinicians.

2.6.4. Copies of the Family Education Manual and links to Recovery videos featuring family members for all Family Education Clinicians.

2.6.5. Copies of the SEE manual and links to recovery videos featuring clients who are working an/or in school for all SEE Specialists.

2.6.6. Copies of the Prescriber's Manual and links to Recovery videos featuring clients talking about the role of medication in their recovery for all prescribers.

2.7. The Contractor shall provide certification requirements to FEP team members, which shall include, but not be limited to:

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

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

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

2.7.1.2.1. Providing consultation data that indicates a minimum of 80% of clients served are being prescribed according to the NAVIGATE model.

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

2.7.1.2.3. Presenting a minimum of two (2) randomly selected cases that shall be judged by the NAVIGATE consultant to determine if the NAVIGATE prescribing model was utilized.

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

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

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

2.7.2.2.1. NAVIGATE team meetings.

2.7.2.2.2. IRT supervision.

2.7.2.2.3. Family supervision.

2.7.2.2.4. SEE supervison.

2.7.2.2.5. Collaborative treatment planning meetings.

2.7.2.2.6. Accompaniments of SEE specialist community visits.

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

2.7.2.4. Responding to the NAVIGANT consultant's feedback on team meetings.

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

2.7.2.5.1. Conducting a minimum of 80% of the required meetings.

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

2.7.2.5.3. Achieving an average of 3 on the Team Fidelity Scale as assessed by the NAVIGATE Director/Family consultant.

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

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

2.7.3.2. Audiotaping IRT sessions and completing IRT contact sheets.

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

2.7.3.4. Responding to NAVIGATE consultant feedback on tapes and contact sheets providing in Section 2.7.3.3.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.7.5.1. Participating in a minimum of 42 meetings about SEE.

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

2.7.5.3. Providing sufficient information to the SEE NAVIGATE Consultant in order for the consultant to complete the Kansas Employment Specialist Job Performance Evaluation Scale and the NAVIGATE SEE Fidelity Scale, which may include role plays with the consultant in order to complete the entire assessment.

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

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

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

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

2.7.5.6.2. Demonstration of satisfactory ratings on both NAVIGATE SEE Fidelity Scale and the Kansas Employment Specialist Job Performance Evaluation Scale.

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

2.8. The Contractor shall provide Team Fidelity and Clinical Provider certification requirements to the Community Mental Health Centers, which shall include, but not be limited to:

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

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

2.8.3. Attendance to a one (1) hour webinar that describes new developments in the field of FEP.

2.8.4. Attendance to a minimum of two (2) hours of webinars that describe new strategies and skills for the implementation of NAVIGATE, specifically.

2.8.5. Submitting examples of current work in accordance with each team member's discipline.

2.9. The Contractor shall provide Trainer Certification and Trainer Re-Certification opportunities to all individuals who have completed clinical certification requirements. The Contractor shall:

2.9.1. Notify the Department, in writing, of potential trainers in each of the Community Mental Health Centers.

2.9.2. Provide the Department with a written plan to increase the number of FEP trainers available to other Community Mental Health Centers that do not have FEP Teams in place.

3. Reporting

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

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

3.1.1.1. Specific contacts made to Community Mental Health Centers.

3.1.1.2. Barriers experienced with obtaining Community Mental Health Center buy-in for FEP Teams.

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

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

3.1.3. A narrative report on the in-person training conducted for NAVIGATE teams, which shall include but not be limited to:

3.1.3.1. Roles and attendance.

3.1.3.2. Brief assessment of strengths for each team.

3.1.3.3. Brief assessment of challenges for each team.

3.1.4. A narrative report on follow-up consultation by NAVIGATE Trainer/Consultants on conducting of each NAVIGATE component.

3.1.5. A narrative report that outlines trouble-shooting activities conducted during overall implementation of the model.

3.1.6. Written recommendations for the following quarter.

4. Deliverables

4.1. The Contractor shall provide a timeline for implementation rollout as described in Section 2.5 to the Department for approval within ten (10) days of the contract effective date.

4.2. The Contractor shall commence implementation of Phase 1 in Section 2.5.1 no later than 60 days prior to providing hands-on training described in Section 2.5.2 (Phase 2).

4.3. The Contractor shall provide an overview of Phase 2 and Phase 3 format requirements to the Department no later than thirty (30) days prior to providing Intensive Staff Training described in Section 2.5.2 (Phase 2).

4.4. The Contractor shall provide all reference materials that supplement the trainings no later than 14 days before the commencement of the Intensive Staff Training described in Section 2.5.2 (Phase 2).

4.5. The Contractor shall provide formal and detailed certification and recertification requirements as described in Section 2.7 to the Department and to the FEP teams at the Community Mental Health Centers within fifteen (15) days of the contract effective date.

4.6. The Contractor shall provide all NAVIGATE fidelity scales to be used, including but not limited to: SEE, prescribing model, Director Fidelity Scale, Team Fidelity Scale, and IRT, to the Department no later than thirty (30) days prior to providing Intensive Staff Training described in Section 2.5.2 (Phase 2).

4.7. The Contractor shall provide quarterly reports, as described in Section 3, every ninety (90) days, beginning no later than 45 days after the contract effective date and continuing to the contract end date.

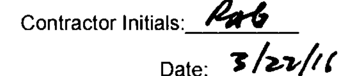
Exhibit B

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, block 1.8, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. This contract is funded with general and federal funds. Department access to supporting funding for this project is dependent upon the criteria set forth in the Catalog of Federal Domestic Assistance (CFDA) (https://www.cfda.gov) #93.778 US Department of Health & Human Services, Centers for Medicare and Medicaid Services.
3. The Contractor shall use and apply all contract funds for authorized direct and indirect costs to provide services in Exhibit A, Scope of Services, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget.
4. The Contractor shall not use or apply contract funds for capital additions or improvements, entertainment costs, or any other costs not approved by the Department.
5. Payment for services provided in accordance with Exhibit A, Scope of Services, shall be made as follows:
   - 5.1. Payments shall be made on cost reimbursement basis only, for allowable expenses and in accordance with Exhibits B-1, Budget through Exhibit B-2, Budget.
   - 5.2. Allowable costs and expenses shall include those expenses detailed in Exhibit B-1, Budget through Exhibit B-2, Budget.
   - 5.3. The Contractor shall submit monthly invoices using invoice forms provided by the Department, and will reference contract budget detail on each invoice.
   - 5.4. The Contractor shall submit supporting documentation and required reports in Exhibit A, Scope of Services, Section 4, that support evidence of actual expenditures, in accordance with Exhibit B-1, Budget through Exhibit B-2, Budget for the previous month by the tenth (10th) working of the current month.
   - 5.5. The invoices for services outlined in Exhibit B-1, Budget, through Exhibit B-2 Budget shall be submitted preferably by e-mail on Department approved invoices to:

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

Contractor Initials:



Date: 3/22/16

Exhibit B

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

6. A final payment request shall be submitted no later than forty (40) days from the Form P37, General Provisions, Contract Completion Date, Block 1.7.

7. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this Contract may be withheld, in whole or in part, in the event of noncompliance with any State or Federal law, rule or regulation applicable to the services provided, or if the said services have not been completed in accordance with the terms and conditions of this Agreement.

8. Notwithstanding paragraph 18 of the Form P-37, General Provisions, an amendment limited to transfer the funds within the budgets in Exhibit B-1 and Exhibit B-2 and within the price limitation, can be made by written agreement of both parties and may be made without obtaining approval of the Governor and Executive Council.

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

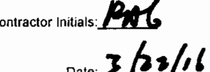
Bidder/Program Name: **Mary Hitchcock Memorial Hospital**

Budget Request for: **Trainer for First Episode Psychosis (FEP) Treatment Services**

Budget Period: **April 1, 2016 through June 30, 2016**

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total	Direct Incremental	Indirect Fixed	Total
1. Total Salary/Wages	$ 3,813.00	$ -	$ 3,813.00	$ -	$ -	$ -	$ 3,813.00	$ -	$ 3,813.00
2. Employee Benefits	$ 1,257.00	$ -	$ 1,257.00	$ -	$ -	$ -	$ 1,257.00	$ -	$ 1,257.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ 1,397.00	$ -	$ 1,397.00	$ -	$ -	$ -	$ 1,397.00	$ -	$ 1,397.00
6. Travel	$ 1,984.00	$ -	$ 1,984.00	$ -	$ -	$ -	$ 1,984.00	$ -	$ 1,984.00
7. Occupancy		$ -		$ -	$ -	$ -		$ -	$ -
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ 64,467.00	$ -	$ 64,467.00	$ -	$ -	$ -	$ 64,467.00	$ -	$ 64,467.00
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indirect As A Percent of Direct	$ 7,291.00	$ -	$ 7,291.00	$ -	$ -	$ -	$ 7,291.00	$ -	$ 7,291.00
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	$ 80,209.00	$ -	$ 80,209.00	$ -	$ -	$ -	$ 80,209.00	$ -	$ 80,209.00

Indirect As A Percent of Direct 0.0%

Contractor Initials: 

Date: 3/22/16

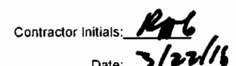
New Hampshire Department of Health and Human Services
COMPLETE ONE BUDGET FORM FOR EACH BUDGET PERIOD

Bidder/Program Name: **Mary Hitchcock Memorial Hospital**

Budget Request for: **Trainer for First Episode Psychosis (FEP) Treatment Services**

Budget Period: **July 1, 2016 through September 30, 2016**

	Total Program Cost			Contractor Share / Match			Funded by DHHS contract share		
Line Item	**Direct Incremental**	**Indirect Fixed**	**Total**	**Direct Incremental**	**Indirect Fixed**	**Total**	**Direct Incremental**	**Indirect Fixed**	**Total**
1. Total Salary/Wages	$ 3,813.00	$ -	$ 3,813.00	$ -	$ -	$ -	$ 3,813.00	$ -	$ 3,813.00
2. Employee Benefits	$ 1,257.00	$ -	$ 1,257.00	$ -	$ -	$ -	$ 1,257.00	$ -	$ 1,257.00
3. Consultants	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. Equipment:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rental	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Repair and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchase/Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Supplies:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Educational	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Lab	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Medical	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Office	$ 1,397.00	$ -	$ 1,397.00	$ -	$ -	$ -	$ 1,397.00	$ -	$ 1,397.00
6. Travel	$ 1,984.00	$ -	$ 1,984.00	$ -	$ -	$ -	$ 1,984.00	$ -	$ 1,984.00
7. Occupancy	$ 597.00	$ -	$ 597.00	$ -	$ -	$ -	$ 597.00	$ -	$ 597.00
8. Current Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Telephone	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Postage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subscriptions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Audit and Legal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Board Expenses	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9. Software	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10. Marketing/Communications	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
11. Staff Education and Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
12. Subcontracts/Agreements	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
13. Other (specific details mandatory):	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Indirect As A Percent of Direct	$ 904.00	$ -	$ 904.00	$ -	$ -	$ -	$ 904.00	$ -	$ 904.00
	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ 9,952.00**	**$ -**	**$ 9,952.00**	**$ -**	**$ -**	**$ -**	**$ 9,952.00**	**$ -**	**$ 9,952.00**
Indirect As A Percent of Direct		0.0%							

Contractor Initials: 
Date: 3/22/16

SPECIAL PROVISIONS

Contractors Obligations: The Contractor covenants and agrees that all funds received by the Contractor under the Contract shall be used only as payment to the Contractor for services provided to eligible individuals and, in the furtherance of the aforesaid covenants, the Contractor hereby covenants and agrees as follows:

1. **Compliance with Federal and State Laws:** If the Contractor is permitted to determine the eligibility of individuals such eligibility determination shall be made in accordance with applicable federal and state laws, regulations, orders, guidelines, policies and procedures.

2. **Time and Manner of Determination:** Eligibility determinations shall be made on forms provided by the Department for that purpose and shall be made and remade at such times as are prescribed by the Department.

3. **Documentation:** In addition to the determination forms required by the Department, the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.

4. **Fair Hearings:** The Contractor understands that all applicants for services hereunder, as well as individuals declared ineligible have a right to a fair hearing regarding that determination. The Contractor hereby covenants and agrees that all applicants for services shall be permitted to fill out an application form and that each applicant or re-applicant shall be informed of his/her right to a fair hearing in accordance with Department regulations.

5. **Gratuities or Kickbacks:** The Contractor agrees that it is a breach of this Contract to accept or make a payment, gratuity or offer of employment on behalf of the Contractor, any Sub-Contractor or the State in order to influence the performance of the Scope of Work detailed in Exhibit A of this Contract. The State may terminate this Contract and any sub-contract or sub-agreement if it is determined that payments, gratuities or offers of employment of any kind were offered or received by any officials, officers, employees or agents of the Contractor or Sub-Contractor.

6. **Retroactive Payments:** Notwithstanding anything to the contrary contained in the Contract or in any other document, contract or understanding, it is expressly understood and agreed by the parties hereto, that no payments will be made hereunder to reimburse the Contractor for costs incurred for any purpose or for any services provided to any individual prior to the Effective Date of the Contract and no payments shall be made for expenses incurred by the Contractor for any services provided prior to the date on which the individual applies for services or (except as otherwise provided by the federal regulations) prior to a determination that the individual is eligible for such services.

7. **Conditions of Purchase:** Notwithstanding anything to the contrary contained in the Contract, nothing herein contained shall be deemed to obligate or require the Department to purchase services hereunder at a rate which reimburses the Contractor in excess of the Contractors costs, at a rate which exceeds the amounts reasonable and necessary to assure the quality of such service, or at a rate which exceeds the rate charged by the Contractor to ineligible individuals or other third party funders for such service. If at any time during the term of this Contract or after receipt of the Final Expenditure Report hereunder, the Department shall determine that the Contractor has used payments hereunder to reimburse items of expense other than such costs, or has received payment in excess of such costs or in excess of such rates charged by the Contractor to ineligible individuals or other third party funders, the Department may elect to:
   7.1. Renegotiate the rates for payment hereunder, in which event new rates shall be established;
   7.2. Deduct from any future payment to the Contractor the amount of any prior reimbursement in excess of costs;

7.3. Demand repayment of the excess payment by the Contractor in which event failure to make such repayment shall constitute an Event of Default hereunder. When the Contractor is permitted to determine the eligibility of individuals for services, the Contractor agrees to reimburse the Department for all funds paid by the Department to the Contractor for services provided to any individual who is found by the Department to be ineligible for such services at any time during the period of retention of records established herein.

RECORDS: MAINTENANCE, RETENTION, AUDIT, DISCLOSURE AND CONFIDENTIALITY:

8. **Maintenance of Records:** In addition to the eligibility records specified above, the Contractor covenants and agrees to maintain the following records during the Contract Period:
   8.1. Fiscal Records: books, records, documents and other data evidencing and reflecting all costs and other expenses incurred by the Contractor in the performance of the Contract, and all income received or collected by the Contractor during the Contract Period, said records to be maintained in accordance with accounting procedures and practices which sufficiently and properly reflect all such costs and expenses, and which are acceptable to the Department, and to include, without limitation, all ledgers, books, records, and original evidence of costs such as purchase requisitions and orders, vouchers, requisitions for materials, inventories, valuations of in-kind contributions, labor time cards, payrolls, and other records requested or required by the Department.
   8.2. Statistical Records: Statistical, enrollment, attendance or visit records for each recipient of services during the Contract Period, which records shall include all records of application and eligibility (including all forms required to determine eligibility for each such recipient), records regarding the provision of services and all invoices submitted to the Department to obtain payment for such services.
   8.3. Medical Records: Where appropriate and as prescribed by the Department regulations, the Contractor shall retain medical records on each patient/recipient of services.

9. **Audit:** Contractor shall submit an annual audit to the Department within 60 days after the close of the agency fiscal year. It is recommended that the report be prepared in accordance with the provision of Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non Profit Organizations" and the provisions of Standards for Audit of Governmental Organizations, Programs, Activities and Functions, issued by the US General Accounting Office (GAO standards) as they pertain to financial compliance audits.
   9.1. Audit and Review: During the term of this Contract and the period for retention hereunder, the Department, the United States Department of Health and Human Services, and any of their designated representatives shall have access to all reports and records maintained pursuant to the Contract for purposes of audit, examination, excerpts and transcripts.
   9.2. Audit Liabilities: In addition to and not in any way in limitation of obligations of the Contract, it is understood and agreed by the Contractor that the Contractor shall be held liable for any state or federal audit exceptions and shall return to the Department, all payments made under the Contract to which exception has been taken or which have been disallowed because of such an exception.

10. **Confidentiality of Records:** All information, reports, and records maintained hereunder or collected in connection with the performance of the services and the Contract shall be confidential and shall not be disclosed by the Contractor, provided however, that pursuant to state laws and the regulations of the Department regarding the use and disclosure of such information, disclosure may be made to public officials requiring such information in connection with their official duties and for purposes directly connected to the administration of the services and the Contract; and provided further, that the use or disclosure by any party of any information concerning a recipient for any purpose not directly connected with the administration of the Department or the Contractor's responsibilities with respect to purchased services hereunder is prohibited except on written consent of the recipient, his attorney or guardian.

Notwithstanding anything to the contrary contained herein the covenants and conditions contained in the Paragraph shall survive the termination of the Contract for any reason whatsoever.

11. **Reports:** Fiscal and Statistical: The Contractor agrees to submit the following reports at the following times if requested by the Department.
    11.1. Interim Financial Reports: Written interim financial reports containing a detailed description of all costs and non-allowable expenses incurred by the Contractor to the date of the report and containing such other information as shall be deemed satisfactory by the Department to justify the rate of payment hereunder. Such Financial Reports shall be submitted on the form designated by the Department or deemed satisfactory by the Department.
    11.2. Final Report: A final report shall be submitted within thirty (30) days after the end of the term of this Contract. The Final Report shall be in a form satisfactory to the Department and shall contain a summary statement of progress toward goals and objectives stated in the Proposal and other information required by the Department.

12. **Completion of Services:** Disallowance of Costs: Upon the purchase by the Department of the maximum number of units provided for in the Contract and upon payment of the price limitation hereunder, the Contract and all the obligations of the parties hereunder (except such obligations as, by the terms of the Contract are to be performed after the end of the term of this Contract and/or survive the termination of the Contract) shall terminate, provided however, that if, upon review of the Final Expenditure Report the Department shall disallow any expenses claimed by the Contractor as costs hereunder the Department shall retain the right, at its discretion, to deduct the amount of such expenses as are disallowed or to recover such sums from the Contractor.

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

14. **Prior Approval and Copyright Ownership:** All materials (written, video, audio) produced or purchased under the contract shall have prior approval from DHHS before printing, production, distribution or use. The DHHS will retain copyright ownership for any and all original materials produced, including, but not limited to, brochures, resource directories, protocols or guidelines, posters, or reports. Contractor shall not reproduce any materials produced under the contract without prior written approval from DHHS.

15. **Operation of Facilities: Compliance with Laws and Regulations:** In the operation of any facilities for providing services, the Contractor shall comply with all laws, orders and regulations of federal, state, county and municipal authorities and with any direction of any Public Officer or officers pursuant to laws which shall impose an order or duty upon the contractor with respect to the operation of the facility or the provision of the services at such facility. If any governmental license or permit shall be required for the operation of the said facility or the performance of the said services, the Contractor will procure said license or permit, and will at all times comply with the terms and conditions of each such license or permit. In connection with the foregoing requirements, the Contractor hereby covenants and agrees that, during the term of this Contract the facilities shall comply with all rules, orders, regulations, and requirements of the State Office of the Fire Marshal and the local fire protection agency, and shall be in conformance with local building and zoning codes, by-laws and regulations.

16. **Equal Employment Opportunity Plan (EEOP):** The Contractor will provide an Equal Employment Opportunity Plan (EEOP) to the Office for Civil Rights, Office of Justice Programs (OCR), if it has received a single award of $500,000 or more. If the recipient receives $25,000 or more and has 50 or

more employees, it will maintain a current EEOP on file and submit an EEOP Certification Form to the OCR, certifying that its EEOP is on file. For recipients receiving less than $25,000, or public grantees with fewer than 50 employees, regardless of the amount of the award, the recipient will provide an EEOP Certification Form to the OCR certifying it is not required to submit or maintain an EEOP. Non-profit organizations, Indian Tribes, and medical and educational institutions are exempt from the EEOP requirement, but are required to submit a certification form to the OCR to claim the exemption. EEOP Certification Forms are available at: http://www.ojp.usdoj/about/ocr/pdfs/cert.pdf.

17. **Limited English Proficiency (LEP):** As clarified by Executive Order 13166, Improving Access to Services for persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination on the basis of limited English proficiency (LEP). To ensure compliance with the Omnibus Crime Control and Safe Streets Act of 1968 and Title VI of the Civil Rights Act of 1964, Contractors must take reasonable steps to ensure that LEP persons have meaningful access to its programs.

18. **Pilot Program for Enhancement of Contractor Employee Whistleblower Protections:** The following shall apply to all contracts that exceed the Simplified Acquisition Threshold as defined in 48 CFR 2.101 (currently, $150,000)

    CONTRACTOR EMPLOYEE WHISTLEBLOWER RIGHTS AND REQUIREMENT TO INFORM EMPLOYEES OF WHISTLEBLOWER RIGHTS (SEP 2013)

    (a) This contract and employees working on this contract will be subject to the whistleblower rights and remedies in the pilot program on Contractor employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

    (b) The Contractor shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

    (c) The Contractor shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

19. **Subcontractors:** DHHS recognizes that the Contractor may choose to use subcontractors with greater expertise to perform certain health care services or functions for efficiency or convenience, but the Contractor shall retain the responsibility and accountability for the function(s). Prior to subcontracting, the Contractor shall evaluate the subcontractor's ability to perform the delegated function(s). This is accomplished through a written agreement that specifies activities and reporting responsibilities of the subcontractor and provides for revoking the delegation or imposing sanctions if the subcontractor's performance is not adequate. Subcontractors are subject to the same contractual conditions as the Contractor and the Contractor is responsible to ensure subcontractor compliance with those conditions.
    When the Contractor delegates a function to a subcontractor, the Contractor shall do the following:
    - 19.1. Evaluate the prospective subcontractor's ability to perform the activities, before delegating the function
    - 19.2. Have a written agreement with the subcontractor that specifies activities and reporting responsibilities and how sanctions/revocation will be managed if the subcontractor's performance is not adequate
    - 19.3. Monitor the subcontractor's performance on an ongoing basis

19.4. Provide to DHHS an annual schedule identifying all subcontractors, delegated functions and responsibilities, and when the subcontractor's performance will be reviewed

19.5. DHHS shall, at its discretion, review and approve all subcontracts.

If the Contractor identifies deficiencies or areas for improvement are identified, the Contractor shall take corrective action.

DEFINITIONS

As used in the Contract, the following terms shall have the following meanings:

COSTS: Shall mean those direct and indirect items of expense determined by the Department to be allowable and reimbursable in accordance with cost and accounting principles established in accordance with state and federal laws, regulations, rules and orders.

DEPARTMENT: NH Department of Health and Human Services.

FINANCIAL MANAGEMENT GUIDELINES: Shall mean that section of the Contractor Manual which is entitled "Financial Management Guidelines" and which contains the regulations governing the financial activities of contractor agencies which have contracted with the State of NH to receive funds.

PROPOSAL: If applicable, shall mean the document submitted by the Contractor on a form or forms required by the Department and containing a description of the Services to be provided to eligible individuals by the Contractor in accordance with the terms and conditions of the Contract and setting forth the total cost and sources of revenue for each service to be provided under the Contract.

UNIT: For each service that the Contractor is to provide to eligible individuals hereunder, shall mean that period of time or that specified activity determined by the Department and specified in Exhibit B of the Contract.

FEDERAL/STATE LAW: Wherever federal or state laws, regulations, rules, orders, and policies, etc. are referred to in the Contract, the said reference shall be deemed to mean all such laws, regulations, etc. as they may be amended or revised from the time to time.

CONTRACTOR MANUAL: Shall mean that document prepared by the NH Department of Administrative Services containing a compilation of all regulations promulgated pursuant to the New Hampshire Administrative Procedures Act. NH RSA Ch 541-A, for the purpose of implementing State of NH and federal regulations promulgated thereunder.

SUPPLANTING OTHER FEDERAL FUNDS: The Contractor guarantees that funds provided under this Contract will not supplant any existing federal funds available for these services.

REVISIONS TO GENERAL PROVISIONS

1. Subparagraph 4 of the General Provisions of this contract, Conditional Nature of Agreement, is replaced as follows:

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

2. Subparagraph 10 of the General Provisions of this contract, Termination, is amended by adding the following language;

   10.1 The State may terminate the Agreement at any time for any reason, at the sole discretion of the State, 30 days after giving the Contractor written notice that the State is exercising its option to terminate the Agreement.

   10.2 In the event of early termination, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement, including but not limited to, identifying the present and future needs of clients receiving services under the Agreement and establishes a process to meet those needs.

   10.3 The Contractor shall fully cooperate with the State and shall promptly provide detailed information to support the Transition Plan including, but not limited to, any information or data requested by the State related to the termination of the Agreement and Transition Plan and shall provide ongoing communication and revisions of the Transition Plan to the State as requested.

   10.4 In the event that services under the Agreement, including but not limited to clients receiving services under the Agreement are transitioned to having services delivered by another entity including contracted providers or the State, the Contractor shall provide a process for uninterrupted delivery of services in the Transition Plan.

   10.5 The Contractor shall establish a method of notifying clients and other affected individuals about the transition. The Contractor shall include the proposed communications in its Transition Plan submitted to the State as described above.

3. The Division reserves the right to renew the Contract for up to two additional years, subject to the continued availability of funds, satisfactory performance of services and approval by the Governor and Executive Council.

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

ALTERNATIVE I - FOR GRANTEES OTHER THAN INDIVIDUALS

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

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

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

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

has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

1.6. Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph 1.4.2, with respect to any employee who is so convicted
   1.6.1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   1.6.2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

1.7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6.

2. The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant.

Place of Performance (street address, city, county, state, zip code) (list each location)

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

Contractor Name:

_______________ Date

[signature]
Name:
Title:

CERTIFICATION REGARDING LOBBYING

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

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

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

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

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

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

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

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

Contractor Name:

3/22/16
Date

[signature] MD
Name:
Title:

CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER RESPONSIBILITY MATTERS

The Contractor identified in Section 1.3 of the General Provisions agrees to comply with the provisions of Executive Office of the President, Executive Order 12549 and 45 CFR Part 76 regarding Debarment, Suspension, and Other Responsibility Matters, and further agrees to have the Contractor's representative, as identified in Sections 1.11 and 1.12 of the General Provisions execute the following Certification:

INSTRUCTIONS FOR CERTIFICATION

1. By signing and submitting this proposal (contract), the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The certification or explanation will be considered in connection with the NH Department of Health and Human Services' (DHHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when DHHS determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, DHHS may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the DHHS agency to whom this proposal (contract) is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549: 45 CFR Part 76. See the attached definitions.

6. The prospective primary participant agrees by submitting this proposal (contract) that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by DHHS.

7. The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided by DHHS, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or involuntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List (of excluded parties).

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and

information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal government, DHHS may terminate this transaction for cause or default.

PRIMARY COVERED TRANSACTIONS

11. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:
    - 11.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
    - 11.2. have not within a three-year period preceding this proposal (contract) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or a contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
    - 11.3. are not presently indicted for otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (l)(b) of this certification; and
    - 11.4. have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

12. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal (contract).

LOWER TIER COVERED TRANSACTIONS

13. By signing and submitting this lower tier proposal (contract), the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:
    - 13.1. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
    - 13.2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal (contract).

14. The prospective lower tier participant further agrees by submitting this proposal (contract) that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

Contractor Name:

3/22/16
Date

Name:
Title:

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

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

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

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

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

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

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

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

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

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

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

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

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

In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, or sex against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, to the applicable contracting agency or division within the Department of Health and Human Services, and to the Department of Health and Human Services Office of the Ombudsman.

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

1. By signing and submitting this proposal (contract) the Contractor agrees to comply with the provisions indicated above.

Contractor Name:

3/22/16
Date

[signature] MD
Name:
Title:

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 per day and/or the imposition of an administrative compliance order on the responsible entity.

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

1. By signing and submitting this contract, the Contractor agrees to make reasonable efforts to comply with all applicable provisions of Public Law 103-227, Part C, known as the Pro-Children Act of 1994.

Contractor Name:

3/22/16
Date

Name:
Title:

HEALTH INSURANCE PORTABLITY ACT
BUSINESS ASSOCIATE AGREEMENT

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

(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

Contractor Initials KAL

Date 3/22/16

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

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

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

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

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

(2) **Business Associate Use and Disclosure of Protected Health Information.**

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

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

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

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

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

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

(3) Obligations and Activities of Business Associate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Obligations of Covered Entity

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

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

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

(5) Termination for Cause

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

(6) Miscellaneous

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

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

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

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

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

f. Survival. Provisions in this Exhibit I regarding the use and disclosure of PHI, return or destruction of PHI, extensions of the protections of the Agreement in section (3) I, the defense and indemnification provisions of section (3) e and Paragraph 13 of the standard terms and conditions (P-37), shall survive the termination of the Agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Exhibit I.

[signature]	Mary Hitchcock Memorial Hospital
The State	Name of the Contractor
	[signature] MD
Signature of Authorized Representative	Signature of Authorized Representative
Katja S Fox	Robert A. Greene
Name of Authorized Representative	Name of Authorized Representative
Director	EVP Chief Population Health Management Officer
Title of Authorized Representative	Title of Authorized Representative
4/7/16	3/22/16
Date	Date

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

The Federal Funding Accountability and Transparency Act (FFATA) requires prime awardees of individual Federal grants equal to or greater than $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:

3/22/16
Date

[signature]
Name:
Title:

FORM A

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

1. The DUNS number for your entity is: 069910297

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?

   ✓ 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: __________

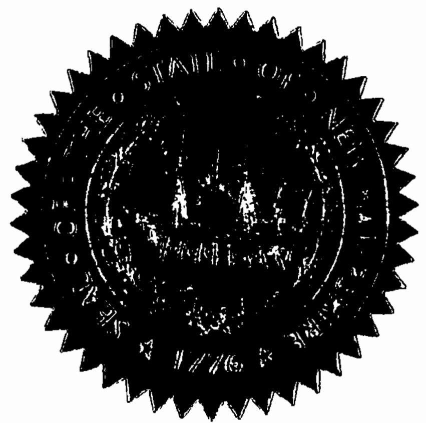
   Name: ____________________ Amount: __________

   Name: ____________________ Amount: __________

State of New Hampshire
Department of State

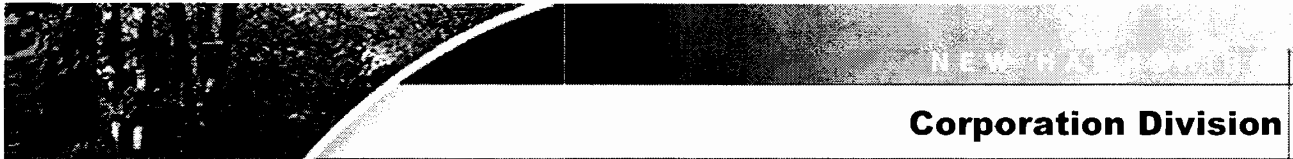
CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify that MARY HITCHCOCK MEMORIAL HOSPITAL is a New Hampshire nonprofit corporation formed August 7, 1889. I further certify that it is in good standing as far as this office is concerned, having filed the return(s) and paid the fees required by law.



In TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed the Seal of the State of New Hampshire, this 8th day of April, A.D. 2015

William M. Gardner
Secretary of State



Search
By Business Name
By Business ID
By Registered Agent
Annual Report
File Online
Guidelines
Name Availability
Name Appeal Process

Date: 4/8/2016

Filed Documents
(Annual Report History, View Images, etc.)

Business Name History

Name	**Name Type**
MARY HITCHCOCK MEMORIAL HOSPITAL	Legal

Non-Profit Corporation - Domestic - Information

Business ID:	68517
Status:	Good Standing
Entity Creation Date:	8/7/1889
Principal Office Address:	One Medical Center Drive Lebanon NH 03756
Principal Mailing Address:	No Address
Expiration Date:	Perpetual
Last Annual Report Filed Date:	9/22/2015 10:56:03 AM
Last Annual Report Filed:	2015

Registered Agent

Agent Name:	
Office Address:	No Address
Mailing Address:	No Address

Important Note: The status reflected for each entity on this website only refers to the status of the entity's filing requirements with this office. It does not necessarily reflect the disciplinary status of the entity with any state agency. Requests for disciplinary information should be directed to agencies with licensing or other regulatory authority over the entity.

Privacy Policy | Accessibility Policy | Site Map | Contact Us

Dartmouth-Hitchcock

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

CERTIFICATE OF VOTE/AUTHORITY

I, Charles G. Plimpton, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand as the Treasurer of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 6th day of April, 2016.

Charles G. Plimpton, Board Treasurer

STATE OF NH

COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 6th day of April, 2016, by Charles G. Plimpton.

LAURA K. ROGERS · STATE OF NEW HAMPSHIRE · NOTARY PUBLIC · MY COMMISSION EXPIRES MAY 9, 2017

Notary Public
My Commission Expires: May 9, 2017

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

CERTIFICATE OF VOTE/AUTHORITY

I, Anne-Lee Verville, of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital, do hereby certify that:

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

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

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

IN WITNESS WHEREOF, I have hereunto set my hand as the Chair of the Board of Trustees of Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital this 15th day of March, 2016.

Anne-Lee Verville, Board Chair

STATE OF NH
COUNTY OF GRAFTON

The foregoing instrument was acknowledged before me this 15th day of March, 2016, by Anne-Lee Verville.

LAURA K. ROGERS
STATE OF NEW HAMPSHIRE
MY COMMISSION EXPIRES MAY 9, 2017
NOTARY PUBLIC

Notary Public
My Commission Expires: May 9, 2017

CERTIFICATE OF INSURANCE

DATE: March 22, 2016

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

INSURED
Mary Hitchcock Memorial Hospital
One Medical Center Drive
Lebanon, NH 03756
(603)653-6850

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

COVERAGES

This is to certify that the Policy listed below have been issued to the Named Insured above for the Policy Period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies. Limits shown may have been reduced by paid claims.
This policy issued by a risk retention group may not be subject to all insurance laws and regulations in all states. State insurance insolvency funds are not available to a risk retention group policy.

	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE	LIMITS	
GENERAL LIABILITY		0002015-A	07/01/2015	06/30/2016	GENERAL AGGREGATE	$2,000,000
					PRODUCTS-COMP/OP AGGREGATE	
X	COMMERCIAL GENERAL LIABILITY				PERSONAL ADV INJURY	
					EACH OCCURRENCE	$1,000,000
x	CLAIMS MADE				FIRE DAMAGE	
	OCCURRENCE				MEDICAL EXPENSES	
PROFESSIONAL LIABILITY		0002015-A	07/01/2015	06/30/2016	EACH OCCURENCE	$1,000,000
					ANNUAL AGGREGATE	$3,000,000
OTHER						

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

Certificate of Insurance issued as evidence of insurance for activities related to the State of New Hampshire Contract.

CERTIFICATE HOLDER
State of New Hampshire
129 Pleasant Street- Brown Bldg
Concord, NH 03301

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

AUTHORIZED REPRESENTATIVES

Client#: 317075 DARTMOUTHH1

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/15/2016

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

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

PRODUCER
HUB Healthcare Solutions
HUB International New England
100 Central Street, 2nd Floor
Holliston, MA 01746

CONTACT NAME: Jessica Kelley
PHONE (A/C, No, Ext): 978-661-6233 FAX (A/C, No): 866-381-4798
E-MAIL ADDRESS: jessica.kelley@hubinternational.com

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

INSURED
Dartmouth Hitchcock Medical Center
1 Medical Center Dr., #4b
Lebanon, NH 03756

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		AGC4053417	07/01/2015	07/01/2016	X WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$1000000
							E.L. DISEASE - EA EMPLOYEE	$1000000
							E.L. DISEASE - POLICY LIMIT	$1000000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Evidence of Workers Compensation coverage.

CERTIFICATE HOLDER

State of New Hampshire
Attn: Denise Shelburne
Contracts & Procurement Unit 129
Pleasant Street - Brown Bldg.
Concord, NH 03301

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

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Mission, Vision, & Values

Our Mission

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

Our Vision

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

Values

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

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Dartmouth-Hitchcock Health and Subsidiaries

Consolidated Financial Statements
June 30, 2015 and 2014

Dartmouth-Hitchcock Health and Subsidiaries
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June 30, 2015 and 2014

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Independent Auditor's Report

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

We have audited the accompanying consolidated financial statements of Dartmouth-Hitchcock Health and Subsidiaries (the "Health System"), which comprise the consolidated balance sheets as of June 30, 2015 and 2014, and the related consolidated statements of operations and changes in net assets and of cash flows for the years ended June 30, 2015 and 2014.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We did not audit the consolidated financial statements of The Cheshire Medical Center, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets constituting 9.7% of consolidated total assets at June 30, 2015 and total revenues of 3.5% of consolidated total revenues for the year then ended. Those statements as of June 30, 2015 and for the four months then ended were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for The Cheshire Medical Center, is based solely on the report of the other auditors. We did not audit the consolidated financial statements of New London Hospital Association, Inc. and Subsidiaries, a subsidiary whose sole member is Dartmouth-Hitchcock Health, which statements reflect total assets constituting 3.8% of consolidated total assets at June 30, 2014 and total revenues of 3.0% of consolidated total revenues for the year then ended. Those statements as of June 30, 2014 and for the nine months then ended were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for New London Hospital Association, Inc. and Subsidiaries, is based solely on the report of the other auditors. We conducted our audit 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.

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

Opinion

In our opinion, based on our audits and the reports of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Health System at June 30, 2015 and 2014, and the results of its operations and changes in net assets and its cash flows for the years ended June 30, 2015 and 2014 in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

As discussed in Note 2 to the consolidated financial statements, the Health System changed the manner in which it accounts for investment gains and losses recognized within periodic pension cost in 2015. 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 audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole. The consolidating information is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations and changes in unrestricted net assets 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 and results of operations and changes in unrestricted net assets of the individual companies.

PricewaterhouseCoopers LLP

November 27, 2015

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

Dartmouth-Hitchcock Health and Subsidiaries
Consolidated Balance Sheets
June 30, 2015 and 2014

(in thousands of dollars)	2015	2014
Assets		
Current assets		
Cash and cash equivalents	$ 38,909	$ 50,927
Patient accounts receivable, net of estimated uncollectibles of $92,532 and $124,404 at June 30, 2015 and 2014 (Note 4)	204,272	184,606
Prepaid expenses and other current assets (Note 13)	100,586	91,302
Total current assets	343,767	326,835
Assets limited as to use (Notes 5, 7, and 10)	620,425	629,185
Other investments for restricted activities (Notes 5 and 7)	132,016	101,675
Property, plant, and equipment, net (Note 6)	601,355	484,753
Other assets	88,450	72,508
Total assets	$ 1,786,013	$ 1,614,956
Liabilities and Net Assets		
Current liabilities		
Current portion of long-term debt (Note 10)	$ 17,179	$ 13,281
Line of credit (Note 13)	1,200	-
Current portion of liability for pension and other postretirement plan benefits (Note 11)	5,961	5,142
Accounts payable and accrued expenses (Note 13)	120,221	93,023
Accrued compensation and related benefits	94,864	78,575
Estimated third-party settlements (Note 4)	36,599	30,677
Total current liabilities	276,024	220,698
Long-term debt, excluding current portion (Note 10)	575,484	550,703
Insurance deposits and related liabilities (Note 12)	62,356	68,498
Interest rate swaps (Notes 7 and 10)	24,740	24,413
Liability for pension and other postretirement plan benefits, excluding current portion (Note 11)	187,568	139,056
Other liabilities	56,109	47,980
Total liabilities	1,182,281	1,051,348
Net assets		
Unrestricted (Note 9)	474,194	462,675
Temporarily restricted (Notes 8 and 9)	76,457	64,664
Permanently restricted (Notes 8 and 9)	53,081	36,269
Total net assets	603,732	563,608
Commitments and contingencies (Notes 4, 6, 7, 10, and 13)	-	-
Total liabilities and net assets	$ 1,786,013	$ 1,614,956

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, 2015 and 2014

(in thousands of dollars)	2015	2014
Unrestricted revenue and other support		
Net patient service revenue, net of provision for bad debt ($17,562 and $47,606 in 2015 and 2014), (Notes 1 and 4)	$ 1,380,559	$ 1,229,848
Contracted revenue (Note 2)	80,835	92,390
Other operating revenue (Note 2 and 5)	82,993	64,804
Net assets released from restrictions	15,637	11,670
Total unrestricted revenue and other support	1,560,024	1,398,712
Operating expenses		
Salaries	776,402	675,716
Employee benefits	213,975	209,052
Medical supplies and medications	219,967	196,397
Purchased services and other	205,704	169,956
Medicaid enhancement tax (Note 4)	51,996	34,488
Depreciation and amortization	67,213	57,729
Interest (Note 10)	18,442	18,436
Expenditures relating to net assets released from restrictions	15,637	11,670
Total operating expenses	1,569,336	1,373,444
Operating (loss) gain	(9,312)	25,268
Nonoperating gains (losses)		
Investment (losses) gains (Notes 5 and 10)	(11,015)	56,804
Other losses	(1,241)	(4,473)
Contribution revenue from acquisition (Note 3)	92,499	33,692
Total nonoperating gains (losses), net	80,243	86,023
Excess of revenue over expenses	$ 70,931	$ 111,291

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, 2015 and 2014

(in thousands of dollars)	**2015**	**2014**
Unrestricted net assets		
Excess of revenue over expenses	$ 70,931	$ 111,291
Net assets released from restrictions	2,411	763
Change in funded status of pension and other postretirement benefits (Note 11)	(60,892)	19,669
Change in fair value of interest rate swaps (Note 10)	(931)	1,538
Increase in unrestricted net assets	11,519	133,261
Temporarily restricted net assets		
Gifts, bequests, sponsored activities	10,625	18,295
Investment gains	1,797	1,171
Change in net unrealized (losses) gains on investments	(1,619)	2,998
Net assets released from restrictions	(18,048)	(12,433)
Contribution of temporarily restricted net assets from acquisition	19,038	386
Increase in temporarily restricted net assets	11,793	10,417
Permanently restricted net assets		
Gifts and bequests	202	2,961
Contribution of permanently restricted net assets from acquisition	16,610	2,053
Increase in permanently restricted net assets	16,812	5,014
Change in net assets	40,124	148,692
Net assets		
Beginning of year	563,608	414,916
End of year	$ 603,732	$ 563,608

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, 2015 and 2014

(in thousands of dollars)	2015	2014
Cash flows from operating activities		
Change in net assets	$ 40,124	$ 148,692
Adjustments to reconcile change in net assets to net cash provided by operating and nonoperating activities		
Change in fair value of interest rate swaps	(104)	(968)
Provision for bad debt	17,562	47,606
Depreciation and amortization	67,414	58,216
Contribution revenue from acquisition	(128,147)	(36,131)
Change in funded status of pension and other postretirement benefits	60,892	(19,669)
Loss on disposal of fixed assets	670	313
Net realized (loses) gains and change in net unrealized (losses) gains on investments	15,795	(58,024)
Restricted contributions	(11,040)	(10,637)
Proceeds from sale of securities	723	413
Changes in assets and liabilities		
Patient accounts receivable, net	(17,151)	(54,587)
Prepaid expenses and other current assets	9,165	(7,669)
Other assets, net	(4,388)	(10,623)
Accounts payable and accrued expenses	(5,169)	10,658
Accrued compensation and related benefits	8,684	757
Estimated third-party settlements	2,637	2,389
Insurance deposits and related liabilities	(17,177)	(23,454)
Liability for pension and other postretirement benefits	(25,471)	(14,980)
Other liabilities	(669)	9,489
Net cash provided by operating and nonoperating activities	14,350	41,791
Cash flows from investing activities		
Purchase of property, plant, and equipment	(87,196)	(50,043)
Proceeds from sale of property, plant, and equipment	1,533	3,155
Purchases of investments	(166,589)	(107,216)
Proceeds from maturities and sales of investments	195,950	111,111
Cash received through acquisition	29,914	3,431
Net cash used by investing activities	(26,388)	(39,562)
Cash flows from financing activities		
Proceeds from line of credit	60,904	100,000
Payments on line of credit	(60,700)	(100,000)
Repayment of long-term debt	(54,682)	(27,351)
Proceeds from issuance of debt	43,452	17,066
Payment of debt issuance costs	6	(418)
Restricted contributions	11,040	8,519
Net cash provided (used) by financing activities	20	(2,184)
(Decrease) increase in cash and cash equivalents	(12,018)	45
Cash and cash equivalents		
Beginning of year	50,927	50,882
End of year	$ 38,909	$ 50,927
Supplemental cash flow information		
Interest paid	$ 21,659	$ 22,220
Asset appreciation due to affiliations	15,596	6,697
Construction in progress included in accounts payable and accrued expenses	1,955	10,550
Equipment acquired through issuance of capital lease obligations	1,741	744
Donated securities	685	413

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

1. Organization and Community Benefit Commitments

Dartmouth-Hitchcock Health (D-HH) serves as the sole corporate member of Mary Hitchcock Memorial Hospital (MHMH) and Dartmouth-Hitchcock Clinic (DHC) (collectively referred to as "Dartmouth-Hitchcock" (D-H)), New London Hospital Association (NLH), Mt. Ascutney Hospital and Health Center (MAHHC) and The Cheshire Medical Center (Cheshire).

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

D-HH currently operates one tertiary and three community acute care hospitals in NH and VT, one facility providing inpatient and outpatient mental health services, and one facility providing inpatient and outpatient rehabilitation medicine and long-term care. D-HH also operates two physician practices and a nursing home. D-HH operates a graduate level program for health professions and is the principal teaching affiliate of the Geisel School of Medicine (Geisel), a component of Dartmouth College.

D-HH, MHMH, DHC, NLH and Cheshire are New Hampshire (NH) not-for-profit corporations exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). MAHHC is a Vermont (VT) not-for-profit corporation exempt from federal income taxes under Section 501(c)(3) of the IRC.

Fiscal year 2015 includes a full year of operations of D-HH, D-H, NLH, MAHHC and four months of operations of Cheshire. Fiscal year 2014 includes a full year of operations of D-HH, D-H and nine months of operations of NLH (Note 3).

Community Benefits

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

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

The Health System files annual Community Benefits Reports with the States of NH and VT which outline the community and charitable benefits it provides. The broad categories used in the Community Benefit Reports to summarize these benefits are as follows:

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

- *Subsidized health services* are services provided even though there is a financial loss because they meet the needs of the community and would not otherwise be available unless the responsibility was assumed by the govemment.

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

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

- *Community-building activities* include cash, in-kind donations, and budgeted expenditures for the development of programs and partnerships intended to address social and economic determinants of health. Examples include physical improvements and housing, economic development, support system enhancements, environmental improvements, leadership development and training for community members, community health improvement advocacy, and workforce enhancement. Community benefit operations includes costs associated with staff dedicated to administering benefit programs, community health needs assessment costs, and other costs associated with community benefit planning and operations.

- *Charity care (financial assistance)* represents services provided to patients who cannot afford healthcare services due to inadequate financial resources which result from being uninsured or underinsured. For the years ended June 30, 2015 and 2014, the Health System provided financial assistance to patients in the amount of approximately $50,076,000 and $56,372,000, respectively, as measured by gross charges. The estimated cost of providing this care for the years ended June 30, 2015 and 2014 was approximately $20,781,000 and $20,454,000, respectively. The estimated costs of providing charity care services are determined applying a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of costs to charges is calculated using total expenses, less bad debt, divided by gross revenue.

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

- The *uncompensated cost of care for Medicaid* patients reported in the unaudited Community Benefits Reports for 2014 was approximately $109,696,000. The 2015 Community Benefits Reports are expected to be filed in February 2016.

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, 2014:

(Unaudited, in thousands of dollars)

Community health services	$	3,267
Health professional education		28,551
Subsidized health services		7,407
Research		5,421
Financial contributions		7,142
Community building activities		797
Community benefit operations		29
Charity care		20,454
Government-sponsored healthcare services		159,446
Total community benefit value	$	232,514

The Health System also provides a significant amount of uncompensated care to its patients that are reported as provision for bad debts, which is not included in the amounts reported above. During the years ended June 30, 2015 and 2014, the Health System reported a provision for bad debt expense of approximately $17,562,000 and $47,606,000, respectively. The Health System also routinely provides services to Medicare patients at reimbursement levels that are below the costs of the care provided.

2. Summary of Significant Accounting Policies

Basis of Presentation

The consolidated financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America, and have been prepared consistent with the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 954 *Healthcare Entities* (ASC 954), which addresses the accounting for healthcare entities. In accordance with the provisions of ASC 954, net assets and revenue, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, unrestricted net assets are amounts not subject to donor-imposed stipulations and are available for operations. Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained in perpetuity. All significant intercompany transactions have been eliminated upon consolidation.

Use of Estimates

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

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

Changes in unrestricted net assets which are excluded from excess of revenue over expenses, consistent with industry practice, include contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets), change in funded status of pension and other postretirement benefit plans, and the effective portion of the change in fair value of interest rate swaps.

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

The Health System grants credit without collateral to patients. Most are local residents and are insured under third-party arrangements. Additions to the allowance for uncollectible accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for bad debts is based upon management's assessment of historical and expected net collections, business and economic conditions, trends in federal and state governmental healthcare coverage, and other collection indicators (Notes 1 and 4).

Net Patient Service Revenue
Net patient service revenue is reported at the estimated net realizable amounts from patients, third party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors and bad debt expense. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as estimates change or final settlements are determined (Note 4).

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

Other Revenue
The Health System recognizes other revenue which is not related to patient medical care but is central to the day-to-day operations of the Health System. This revenue includes retail pharmacy, joint operating agreements, grant revenue, cafeteria sales, meaningful use incentive payments and other support service revenue.

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

Investments and Investment Income
Investments in equity securities with readily determinable fair values, mutual funds and pooled/comingled funds, and all investments in debt securities are considered to be trading securities reported at fair value with changes in fair value included in the 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 excess of revenues over expenses. All investments, whether held at fair value or under the equity method of accounting, are reported at what the Health System believes to be the amount they would expect to receive if it liquidated its investments at the balance sheets date on a non-distressed basis.

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

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

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

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

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

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

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

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

Property, Plant, and Equipment

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

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

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

Bond Issuance Costs

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

Trade Names

The Health System records trade names as intangible assets within other assets on the consolidated statements of financial position. The Health System considers trade names to be indefinite-lived assets, assesses them at least annually for impairment or more frequently if certain events or circumstances warrant and recognizes impairment charges for amounts by which the carrying values

exceed their fair values. The Health System has recorded $2,700,000 as intangible assets associated with its affiliations. There were no impairment charges recorded for the years ended June 30, 2015 and 2014.

Derivative Instruments and Hedging Activities

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

On the date a derivative contract is entered into, the Health System designates the derivative as a cash-flow hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability. For all hedge relationships, the Health System formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking cash-flow hedges to specific assets and liabilities on the consolidated balance sheets or to specific firm commitments or forecasted transactions. The Health System also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in variability of cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in unrestricted net assets until earnings are affected by the variability in cash flows of the designated hedged item. The ineffective portion of the change in fair value of a cash-flow hedge is reported in excess of revenue over expenses in the consolidated statements of operation and changes in net assets.

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

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

Gifts and Bequests

Unrestricted gifts and bequests are recorded net of related expenses as nonoperating gains. Conditional promises to give and indications of intentions to give to the Health System are reported at fair market value at the date the gift is received. Gifts are reported as either temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

Change in Accounting

During 2015, the Health System elected to change its method of accounting for pension and postretirement benefits. For purposes of calculating the expected return on plan assets, the Health System will no longer use an averaging technique permitted under Generally Accepted Accounting

Principles (GAAP) for the market-related value of plan assets, but instead will use the actual fair value of plan assets. These changes are intended to improve the transparency of the Health System's operating results by more quickly recognizing the effects of current economic and interest rate trends on plan investments and assumptions. These changes have been reported through retrospective application to all periods presented. The impact of the change in accounting for the years ended June 30, 2015 and 2014 was an approximate (reduction) increase in pension expense of ($4,800,000) and $4,900,000, respectively.

Recently Issued Accounting Pronouncements
In May 2014, the FASB issued a standard on Revenue from Contracts with Customers. This standard implements a single framework for recognition of all revenue earned from customers. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services by allocating transaction price to identified performance obligations and recognizing revenue as performance obligations are satisfied. Qualitative and quantitative disclosures are required to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The standard is effective for fiscal years beginning after December 15, 2017. The Health System is evaluating the impact this will have on the combined financial statements beginning in Fiscal Year 2018.

3. Acquisitions

Effective July 1, 2014 D-HH became the sole corporate member of Windsor Hospital Corporation (dba Mt. Ascutney Hospital and Health Center "MAHHC") through an affiliation agreement. MAHHC is a not-for-profit corporation providing inpatient and outpatient care services to residents of Windsor County, Vermont. MAHHC is the sole corporate member of Historic Homes of Runnemede, Inc. a not-for-profit Vermont corporation providing recreational, educational and residential care services for the aging. In addition, MAHHC is the sole corporate member of Mt. Ascutney Hospital Community Health Foundation, Inc. which is a not-for-profit Vermont corporation providing health education and promotion programs aimed at improving the health status of the Windsor community. MAHHC and its subsidiaries have a fiscal year end of September 30th.

Effective March 2, 2015 D-HH became the sole corporate member of The Cheshire Medical Center (Cheshire) through an affiliation agreement. Cheshire is a not-for-profit acute care hospital providing inpatient and outpatient services to the residents of Merrimack and Sullivan counties. Cheshire is the sole corporate member of The Cheshire Health Foundation (Cheshire Foundation), a not-for-profit corporation that carries on fundraising activities and manages related investments. Cheshire and Cheshire Foundation have a fiscal year end of June 30th. The D-HH's 2015 consolidated financial statements reflect four months of activity for Cheshire and Cheshire Foundation beginning March 2, 2015.

In accordance with applicable accounting guidance on not-for-profit mergers and acquisitions, The Health System recorded contribution income of approximately $128,147,000 reflecting the fair value of the contributed net assets of MAHHC and Cheshire and their subsidiaries on the transaction dates. Of this amount, $92,499,000 represents unrestricted net assets and is included as a nonoperating gain in the accompanying consolidated statements of operations. Restricted contribution income of $19,038,000 and $16,610,000 was recorded within temporarily and permanently restricted net assets, respectively, in the accompanying consolidated statements of changes in net assets. No consideration was exchanged for the net assets contributed and acquisition costs are expensed as incurred.

The fair value of assets, liabilities, and net assets contributed by MAHHC and Cheshire and their subsidiaries at July 1, 2014 and March 2, 2015 were as follows:

(in thousands)

	MAHHC	Cheshire	Total
Assets			
Cash and cash equivalents	$ 4,159	$ 25,755	29,914
Patient accounts receivable, net	7,063	13,014	20,077
Prepaid expenses and other current assets	1,368	3,345	4,713
Assets limited as to use	15,168	46,440	61,608
Property, plant, and equipment, net	17,644	81,275	98,919
Other assets	2,398	5,698	8,096
Total assets acquired	$ 47,800	$ 175,527	223,327
Liabilities			
Accounts payable and accrued expenses	$ 2,174	$ 19,709	21,883
Accrued compensation and related benefits	2,590	5,016	7,606
Estimated third-party settlements	3,285	-	3,285
Long-term debt	10,213	29,052	39,265
Interest rate swaps	431	-	431
Other liabilities	6,693	16,017	22,710
Total liabilities assumed	25,386	69,794	95,180
Net Assets			
Unrestricted	15,672	76,827	92,499
Temporarily restricted	752	18,286	19,038
Permanently restricted	5,990	10,620	16,610
Total net assets	22,414	105,733	128,147
Total liabilities and net assets	$ 47,800	$ 175,527	223,327

A summary of the financial results of MAHHC and Cheshire and their subsidiaries included in the consolidated statements of operations and changes in net assets for the period from the dates of acquisition, July 1, 2014 and March 2, 2015 through June 30, 2015 is as follows:

(in thousands)

	MAHHC	Cheshire	Total
Total operating revenues	$ 49,628	$ 53,824	$ 103,452
Total operating expenses	51,098	55,288	106,386
Operating loss	(1,470)	(1,464)	(2,934)
Nonoperating gains	117	452	569
Deficit of revenues over expenses	(1,353)	(1,012)	(2,365)
Net assets released from restriction used for capital purchases	679	1,010	1,689
Change in funded status of pension and other postretirement benefits	(790)	2,875	2,085
Change in fair value on interest rate swaps	159	-	159
Net assets transferred from affiliate	15,672	76,827	92,499
Increase in unrestricted net assets	$ 14,367	$ 79,700	$ 94,067

A summary of the consolidated financial results of the Health System for the years ended June 30, 2015 and 2014 as if the transactions had occurred on July 1, 2013 is as follows (unaudited):

(in thousands)	2015	2014
Total operating revenues	$ 1,658,250	$ 1,595,128
Total operating expenses	1,671,124	1,572,044
Operating (loss) gain	(12,874)	23,084
Nonoperating gains	81,277	90,522
Excess of revenues over expenses	68,403	113,606
Net assets released from restriction used for capital purchases	2,411	790
Change in funded status of pension and other post retirement benefits	(65,128)	20,017
Change in fair value on interest rate swaps	(931)	1,538
Increase in unrestricted net assets	$ 4,755	$ 135,951

4. Patient Service Revenue and Accounts Receivable

Patient service revenue is reported net of contractual allowances and the provision for bad debts as follows for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Gross patient service revenue	$ 3,656,514	$ 3,235,142
Less: Contractual allowances	2,258,393	1,957,688
Less: Provision for bad debt	17,562	47,606
Net patient service revenue	$ 1,380,559	$ 1,229,848

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

Accounts receivable, prior to adjustment for estimated uncollectibles, are summarized as follows at June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Receivables		
Patients	$ 123,881	$ 156,967
Third-party payors	171,141	150,258
Nonpatient	1,782	1,785
	$ 296,804	$ 309,010

The allowance for estimated uncollectibles is $92,532,000 and $124,404,000 as of June 30, 2015 and 2014.

The following table categorizes payors into five groups and their respective percentages of gross patient service revenue for the years ended June 30, 2015 and 2014:

	2015	2014
Medicare	40 %	39 %
Anthem/Blue Cross	21	20
Commercial insurance	20	21
Medicaid	15	13
Self-pay/Other	4	7
	100 %	100 %

The Health System has agreements with third-party payors that provide for payments at amounts different from their established rates. A summary of the acute care payment arrangements in effect during the years ended June 30, 2015 and 2014 with major third-party payors follows:

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

Certain of the Health System's affiliates qualify as Critical Access Hospitals (CAH), which are reimbursed by Medicare at 101% of reasonable costs for its inpatient acute, swing bed, and outpatient services, excluding ambulance services and inpatient hospice care. They are reimbursed at an interim rate for cost based services with a final settlement determined by the Medicare Cost Report filing. The nursing home is not impacted by CAH designation. Medicare reimburses nursing home care based on an acuity driven prospective payment system with no retrospective settlement.

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

During the years ended June 30, 2015 and 2014, the Health System recorded State of NH Medicaid Enhancement Tax (MET) expense of $51,996,000 and $34,488,000, respectively. The tax is calculated at 5.5% of certain gross patient revenues in accordance with instructions received from the State of NH. The MET expense is included in operating expenses in the consolidated statements of operations and changes in net assets.

On June 30, 2014, the NH Governor signed into law a bi-partisan legislation reflecting an agreement between the State of NH and 25 NH hospitals on the Medicaid Enhancement Tax "SB 369". As part of the agreement the parties have agreed to resolve all pending litigation related to MET and Medicaid Rates, including the Catholic Medical Center Litigation, the Northeast Rehabilitation Litigation, 2014 DRA Refund Requests, and the State Rate Litigation. As part of the Medicaid Enhancement Tax Agreement Effective July 1, 2014, a "Trust / Lock Box" dedicated fund mechanism will be established for receipt and distribution of all MET proceeds with all monies used exclusively to support Medicaid services. During the years ended June 30, 2015 and 2014, the Health System received disproportionate share hospital (DSH) payments of $10,152,016 and $12,631,782, respectively.

The Health Information Technology for Economic and Clinical Health (HITECH) Act included in the American Recovery and Reinvestment Act (ARRA) provides incentives for the adoption and use of health information technology by Medicare and Medicaid providers and eligible professionals over the next several years with an anticipated end date of December 31, 2016, depending on the program. The Health System has recognized $4,175,164 and $6,833,075 in meaningful use incentives for both the Medicare and Vermont Medicaid programs during the years ended June 30, 2015 and 2014, respectively.

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

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

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

The Health System has provided for its estimated final settlements with all payors based upon applicable contracts and reimbursement legislation and timing in effect for all open years (2007 -

2015). The differences between the amounts provided and the actual final settlement, if any, is recorded as an adjustment to net patient service revenue as amounts become known or as years are no longer subject to audits, reviews and investigations. During 2015 and 2014, changes in estimates related to the Health System's settlements with third-party payors resulted in increases in net patient service revenue of approximately $5,550,206 and $4,076,601, respectively, in the consolidated statements of operations and changes in net assets.

5. Investments

The composition of investments at June 30, 2015 and 2014 is set forth in the following table:

(in thousands of dollars)	2015	2014
Assets limited as to use		
Internally designated by board		
Cash and short-term investments	$ 8,475	$ 7,463
U.S. government securities	36,634	36,930
Domestic corporate debt securities	80,254	83,224
Global debt securities	111,156	126,451
Domestic equities	106,350	111,970
International equities	69,965	54,778
Emerging markets equities	36,591	40,344
REIT	621	-
Private equity funds	26,843	25,146
Hedge funds	56,590	50,370
	533,479	536,676
Investments held by captive insurance companies (Note 12)		
U.S. government securities	27,730	45,897
Domestic corporate debt securities	32,017	22,005
Global debt securities	4,883	3,770
Domestic equities	7,669	7,286
International equities	12,869	13,058
	85,168	92,016
Held by trustee under indenture agreement (Note 10)		
Cash and short-term investments	1,778	493
Total assets limited as to use	$ 620,425	$ 629,185

(in thousands of dollars)	2015	2014
Other investments for restricted activities		
Cash and short-term investments	$ 5,448	$ 4,215
U.S. government securities	19,730	13,872
Domestic corporate debt securities	34,548	26,689
Global debt securities	18,947	19,034
Domestic equities	18,354	15,901
International equities	14,777	7,461
Emerging markets equities	5,077	5,162
REIT	533	-
Private equity funds	3,653	3,101
Hedge funds	10,921	6,212
Other	28	28
Total other investments for restricted activities	$ 132,016	$ 101,675

Investments are accounted for using either the fair value method or equity method of accounting, as appropriate on a case by case basis. The fair value method is used when debt securities or equity securities 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, 2015 and 2014. Accounting standards require disclosure of additional information for those securities accounted for using the fair value method, as shown in Note 7.

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

	2014		
(in thousands of dollars)	**Fair Value**	**Equity**	**Total**
Cash and short-term investments	$ 12,171	$ -	$ 12,171
U.S. government securities	96,699	-	96,699
Domestic corporate debt securities	101,467	30,451	131,918
Global debt securities	67,544	81,711	149,255
Domestic equities	123,620	11,537	135,157
International equities	13,763	61,534	75,297
Emerging markets equities	185	45,321	45,506
Private equity funds	-	28,247	28,247
Hedge funds	-	56,582	56,582
Other	28	-	28
	$ 415,477	$ 315,383	$ 730,860

Investment income (losses) is comprised of the following for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Unrestricted		
Interest and dividend income, net	$ 7,927	$ 5,241
Net realized gains on sales of securities	12,432	15,464
Change in net unrealized gains on investments	(28,824)	38,685
	(8,465)	59,390
Temporarily restricted		
Interest and dividend income, net	1,151	294
Net realized gains on sales of securities	646	877
Change in net unrealized gains on investments	(1,619)	2,998
	178	4,169
	$ (8,287)	$ 63,559

For the years ended June 30, 2015 and 2014 unrestricted investment income (losses) is reflected in the accompanying consolidated statements of operations and changes in net assets as operating revenue of approximately $2,550,000 and $2,586,000 and as nonoperating (losses) gains of approximately ($11,015,000) and $56,804,000, 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, 2015 and 2014, the Health System has committed to contribute approximately $105,782,000 and $101,285,000 to such funds, of which the Health System has contributed approximately $66,918,000 and $67,206,000 and has outstanding commitments of $38,864,000 and 34,079,000, respectively.

6. Property, Plant, and Equipment

Property, plant, and equipment are summarized as follows at June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Land	$ 29,558	$ 25,839
Land improvements	31,750	30,450
Buildings and improvements	714,689	619,243
Equipment	590,501	507,077
Equipment under capital leases	17,824	16,128
	1,384,322	1,198,737
Less: Accumulated depreciation and amortization	818,816	729,757
Total depreciable assets, net	565,506	468,980
Construction in progress	35,849	15,773
	$ 601,355	$ 484,753

As of June 30, 2015 and 2014 construction in progress primarily consists of the construction of the Williamson Research building in Lebanon, NH and the renovation for new inpatient and outpatient rehabilitation space at MAHHC. The estimated cost to complete these projects is $8,425,000 and $13,250,000 at June 30, 2015 and 2014, respectively.

Depreciation and amortization expense included in operating and nonoperating activities was approximately $67,414,000 and $58,216,000 for 2015 and 2014, respectively.

7. Fair Value Measurements

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

Cash and short-term investments: Consists of money market funds and are valued at NAV reported by the financial institution.

Domestic, emerging markets and international equities: Consists of actively traded equity securities and mutual funds which are valued at the closing price reported on an active market on which the individual securities are traded (Level 1 measurements).

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

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

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

Investments are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The following tables set forth the consolidated financial assets and liabilities that were accounted for at fair value on a recurring basis as of June 30, 2015 and 2014:

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

(in thousands of dollars)	2014 Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Assets						
Investments						
Cash and short term investments	11,144	$ 1,027	$ -	$ 12,171	Daily	1
U.S. government securities	96,699	-	-	96,699	Daily	1
Domestic corporate debt securities	33,201	68,266	-	101,467	Daily–Monthly	1–15
Global debt securities	57,911	9,633	-	67,544	Daily–Monthly	1–15
Domestic equities	123,620	-	-	123,620	Daily–Monthly	1–10
International equities	13,763	-	-	13,763	Daily–Monthly	1–11
Emerging market equities	185	-	-	185	Daily–Monthly	1–7
Other	-	28	-	28	Not applicable	Not applicable
Total investments	336,523	78,954	-	415,477		
Deferred compensation plan assets						
Cash and short-term investments	2,753	26	-	2,779		
U.S. government securities	80	-	-	80		
Domestic corporate debt securities	4,798	-	-	4,798		
Global debt securities	835	-	-	835		
Domestic equities	19,318	-	-	19,318		
International equities	8,735	-	-	8,735		
Emerging market equities	2,198	-	-	2,198		
Real Estate	1,665	-	-	1,665		
Multi Strategy Fund	6,079	-	-	6,079		
Guaranteed Contract	-	-	75	75		
Total deferred compensation plan assets	46,461	26	75	46,562	Not applicable	Not applicable
Beneficial interest in trusts	-	-	1,909	1,909	Not applicable	Not applicable
Contribution receivable from charitable Remainder trust	-	-	2,118	2,118	Not applicable	Not applicable
Total assets	$ 382,984	$ 78,980	$ 4,102	$ 466,066		
Liabilities						
Interest rate swaps	$ -	$ 24,413	$ -	$ 24,413	Not applicable	Not applicable
Total liabilities	$ -	$ 24,413	$ -	$ 24,413		

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

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

	2014			
	Beneficial Interest in Perpetual Trust	Contribution Receivable From Charitable Remainder Trust	Guaranteed Contract	Total
Balance at beginning of year	$ 1,823	$ -	$ 72	$ 1,895
Purchases	-	2,118	-	2,118
Net unrealized gains (losses)	86	-	3	89
Balance at end of year	$ 1,909	$ 2,118	$ 75	$ 4,102

There were no transfers into and out of Level 1 and Level 2 measurements due to changes in valuation methodologies during the years ended June 30, 2015 and 2014.

8. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Healthcare services	$ 30,368	$ 28,210
Research	16,376	22,699
Purchase of equipment	2,483	2,681
Charity care	16,354	1,511
Health education	9,181	7,688
Other	1,695	1,875
	$ 76,457	$ 64,664

Permanently restricted net assets consist of the following at June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Healthcare services	$ 25,015	$ 15,935
Research	7,689	7,634
Purchase of equipment	6,291	4,675
Charity care	5,609	2,874
Health education	8,454	5,129
Other	23	22
	$ 53,081	$ 36,269

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

9. Board Designated and Endowment Funds

Net assets include approximately 60 individual funds established for a variety of purposes including both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. Net assets associated with endowment funds, including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor-imposed restrictions.

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

Unrestricted net assets include funds designated by the Board of Trustees to function as endowments and the income from certain donor-restricted endowment funds, and any accumulated investment return thereon, which pursuant to donor intent may be expended based on trustee or management designation. Temporarily restricted net assets include funds appropriated for expenditure pursuant to endowment and investment spending policies, certain expendable endowment gifts from donors, and any retained income and appreciation on donor-restricted endowment funds, which are restricted by the donor to a specific purpose or by law. When the temporary restrictions on these funds have been met, the funds are reclassified to unrestricted net assets.

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

The Health System has endowment investment and spending policies that attempt to provide a predictable stream of funding for programs supported by its endowment while ensuring that the purchasing power does not decline over time. The Health System targets a diversified asset

allocation that places emphasis on investments in domestic and international equities, fixed income, private equity, and hedge fund strategies to achieve its long-term return objectives within prudent risk constraints. The Health System's Investment Committee reviews the policy portfolio asset allocations, exposures, and risk profile on an ongoing basis.

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

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below their original contributed value. Such market losses were not material as of June 30, 2015 and 2014.

Endowment net asset composition by type of fund consists of the following at June 30, 2015 and 2014:

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

	2014			
(in thousands of dollars)	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 13,738	$ 34,360	$ 48,098
Board-designated endowment funds	19,834	-		19,834
Total endowed net assets	$ 19,834	$ 13,738	$ 34,360	$ 67,932

Changes in endowment net assets for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at beginning of year	$ 19,834	$ 13,738	$ 34,360	$ 67,932
Net investment return	143	(223)	1	(79)
Contributions	-	974	254	1,228
Transfers	-	(370)	158	(212)
Release of appropriated funds	(664)	(2,425)	(46)	(3,135)
Net asset transfer from affiliates	7,092	16,602	9,764	33,458
Balances at end of year	$ 26,405	$ 28,296	44,491	$ 99,192
Balances at end of year			44,491	
Beneficial interest in perpetual trust			8,590	
Permanently restricted net assets			$ 53,081	

(in thousands of dollars)	2014			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Balances at beginning of year	$ 19,304	$ 11,672	$ 31,255	$ 62,231
Net investment return	341	3,457	-	3,798
Contributions	-	42	809	851
Transfers	450	(280)	243	413
Release of appropriated funds	(261)	(1,539)	-	(1,800)
Net asset transfer from affiliates	-	386	2,053	2,439
Balances at end of year	$ 19,834	$ 13,738	34,360	$ 67,932
Balances at end of year			34,360	
Beneficial interest in perpetual trust			1,909	
Permanently restricted net assets			$ 36,269	

10. Long-Term Debt

A summary of long-term debt at June 30, 2015 and 2014 follows:

(in thousands of dollars)	2015	2014
Variable rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2013, principal maturing in varying annual amounts, through August 2043 (9)*	$ 17,668	$ 17,923
Series 2011, principal maturing in varying annual amounts, through August 2031 (4)	90,005	93,395
Vermont Educational and Health Buildings Financing Agency (VEHFBA) Revenue Bonds		
Series 2010A, principal maturing in varying annual amounts, through August 2030 (8)*	8,182	-
Fixed rate issues		
New Hampshire Health and Education Facilities Authority Revenue Bonds		
Series 2014A, principal maturing in varying annual amounts, through August 2022 (1)	26,960	-
Series 2014B, principal maturing in varying annual amounts, through August 2033 (1)	14,530	-
Series 2012A, principal maturing in varying annual amounts, through August 2031 (2)	73,725	74,695
Series 2012B, principal maturing in varying annual amounts, through August 2031 (2)	40,455	40,990
Series 2012, principal maturing in varying annual amounts, through July 2039 (7)*	28,818	-
Series 2010, principal maturing in varying annual amounts, through August 2040 (5)	75,000	75,000
Series 2009, principal maturing in varying annual amounts, through August 2038 (6)	68,970	115,225
** Represents non-obligated group bonds*		
Other		
Series 2012, principal maturing in varying annual amounts, through July 2019 (3)	144,000	146,000
Obligations under capital leases	3,369	2,086
Note payable to a financial institution payable in interest free monthly installments through July 2015; collateralized by associated equipment	4	56
Note payable to a financial institution due in monthly interest only payments from October 2011 through September 2012, and monthly installments from October 2016 through 2016, including principal and interest at 3.25%; collateralized by savings account	1,915	-
Note payable to a financial institution payable in interest free entire principal due June 2029 collateralized by land and building	555	-
	594,156	565,370
Less		
Original issue discount, net	1,493	1,386
Current portion	17,179	13,281
	$ 575,484	$ 550,703

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

(in thousands of dollars)	2015
2016	$ 17,179
2017	17,493
2018	17,971
2019	18,280
2020	143,235
Thereafter	379,998
	$ 594,156

Dartmouth-Hitchcock Obligated Group (DHOG) Bonds:

MHMH established the DHOG in 1993 for the original purpose of issuing bonds financed through NHHEFA or the "Authority". The members of the obligated group consist of MHMH and DHC.

Revenue Bonds issued by members of the DHOG are administered through notes registered in the name of the Bond Trustee and in accordance with the terms of a Master Trust Indenture. The Master Trust Indenture contains provisions permitting the addition, withdrawal, or consolidation of members of the DHOG under certain conditions. The notes constitute a joint and several obligation of the members of the DHOG (and any other future members of the DHOG) and are equally and ratably collateralized by a pledge of the members' gross receipts. The DHOG is also subject to certain annual covenants under the Master Trust Indenture, the most restrictive of which are the Maximum Annual Debt Service Coverage Ratio (1.10x) and the Days Cash on Hand Ratio (> 75 days).

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

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

(2) Series 2012A and 2012B Revenue Bonds

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

(3) Series 2012 Bank Loan

Through the DHOG, issued the Bank of America, N.A. Series 2012 note, in July 2012. The proceeds from the Series 2012 note were used to prefund the D-H defined benefit pension plan. Interest on the Series 2012 note accrues at a fixed rate of 2.47% and matures at various dates through 2019.

(4) Series 2011 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2011 in August 2011. The proceeds from the Series 2011 Revenue Bonds were primarily used to advance refund the Series 2001A Revenue Bonds. The Series 2011 Revenue Bonds accrue interest variably and mature at various dates through 2031 based on the one-month London Interbank Offered Rate (LIBOR). The variable rate as of June 30, 2015 and 2014 was 1.04% and 1.01%, respectively. The Series 2011 Bonds are callable by the bank upon the end of seven years or may be renegotiated at that time.

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

(6) Series 2009 Revenue Bonds
Through the DHOG, issued NHHEFA Revenue Bonds, Series 2009, in August 2009. The proceeds from the Series 2009 Revenue Bonds were primarily used to advance refund the Series 2008 Revenue Bonds. Interest on the Series 2009 Revenue Bonds accrue at varying fixed rates between 3.00% and 6.00% and mature at various dates through August 2038.

Outstanding joint and several indebtedness of the DHOG at June 30, 2015 and 2014 approximates $533,645,000 and $545,305,000, respectively.

Non Obligated Group Bonds:

(7) Series 2012 Revenue Bonds

Issued through the NHHEFA $29,650,000 of tax-exempt Revenue Bonds (Series 2012). The proceeds of these bonds were used to refund 1998 and 2009 Series Bonds, to finance the settlement cost of the interest rate swap, and to finance the purchase of certain equipment and renovations. The bonds are collateralized by an interest in its gross receipts under the terms of the bond agreement. The bonds have fixed interest coupon rates ranging from 2.0% to 5.0% (a net interest cost of 3.96%). Principal is payable in annual installments ranging from $735,000 to $1,750,000 through July 2039.

(8) Series 2010A Revenue Bonds

Issued through the VEHBFA $9,244,000 of Revenue Bonds (Series 2010A). The funds were used to refund 2004 and 2005 Series A Bonds. The bonds are collateralized by gross receipts. The bonds shall bear interest at the one-month LIBOR rate plus 3.50%, multiplied by 6% adjusting monthly. The interest rate at June 30, 2015 was 2.29%. The bonds were purchased by TD Bank. Principal payments began on April 1, 2010 for a period of 20 years ranging in amounts from $228,000 in 2014 to $207,000 in 2030.

(9) Series 2013 Revenue Bonds

Issued through the NHHEFA $15,520,000 tax exempt Revenue Bonds (Series 2013). The funds were used to refund Series 2007 Revenue Bonds, and for the construction of a new health center building in Newport, NH. The bonds are collateralized by the gross receipts and property. The bonds mature in variable amounts through 2043, the maturity date of the bonds, but are subject to mandatory tender in ten years. Interest is payable monthly and is equal to the sum of .72 times

the Adjusted LIBOR Rate plus .72 times the credit spread rate. As part of the bond refinancing, the swap arrangement was effectively terminated for federal tax purposes with respect to the Series 2007 Revenue Bonds but remains in effect.

The estimated fair value of the Health Systems total long-term debt as of June 30, 2015 and 2014 was approximately $606,772,000 and $555,500,000, respectively, which was determined by discounting the future cash flows of each instrument at rates that reflect rates currently observed in publicly traded debt markets for debt of similar terms to organizations with comparable credit risk. The inputs to the assumptions used to determine the estimated fair value are based on observable inputs and are classified as level 2. For variable rate debt, the carrying value is equal to the fair value.

The Health System Indenture agreements require establishment and maintenance of debt service reserves and other trustee held funds. Trustee held funds of approximately $1,778,000 and $493,000 at June 30, 2015 and 2014, respectively, are classified as assets limited as to use in the accompanying consolidated balance sheets.

For the years ended June 30, 2015 and 2014 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 $18,442,000 and $18,436,000 and is included in other nonoperating losses of $3,449,000 and $3,669,000, respectively.

Swap Agreements

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

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

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

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

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

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

At June 30, 2015 and 2014 the fair value of the Health System's interest rate swaps was a liability of $24,740,000 and $24,413,000, respectively. The change in fair value during the years ended June 30, 2015 and 2014 was a (decrease)/increase of ($931,000) and $1,538,000, respectively. For the years ended June 30, 2015 and 2014 the Health System recognized a non-operating gain/ (loss) of $1,035,000 and ($570,000) resulting from hedge ineffectiveness and amortization of frozen swaps.

11. Employee Benefits

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

All of the defined benefit plans within the Health System have been frozen or have been approved by the applicable Board of Trustees to be frozen by December 31, 2017. Effective with that date, the last of the participants earning benefits in any of the Health System's defined benefit plans will no longer earn benefits under the plans.

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

Defined Benefit Plans

Net periodic pension expense included in employee benefits in the consolidated statements of operations and changes in net assets is comprised of the components listed below for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Service cost for benefits earned during the year	$ 12,257	$ 12,122
Interest cost on projected benefit obligation	42,276	41,821
Expected return on plan assets	(60,458)	(55,177)
Net prior service cost	380	380
Net loss amortization	21,133	17,285
Curtailment	56	-
	$ 15,644	$ 16,431

The following assumptions were used to determine net periodic pension expense as of June 30, 2015 and 2014:

	2015	2014
Weighted average discount rate	4.40 % - 4.90 %	5.50 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded
Expected long-term rate of return on plan assets	7.50 % - 7.75 %	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, 2015 and 2014:

(in thousands of dollars)	2015	2014
Change in benefit obligation		
Benefit obligation at beginning of year	$ 877,082	$ 812,374
Additional benefit obligation resulting from new affiliations	95,314	-
Total benefit obligation at beginning of year	972,396	812,374
Service cost	12,257	12,122
Interest cost	42,276	41,821
Benefits paid	(34,803)	(31,467)
Expenses paid	(139)	-
Actuarial (gain) loss	41,135	94,207
Settlements	(44,979)	(51,975)
Benefit obligation at end of year	988,143	877,082
Change in plan assets		
Fair value of plan assets at beginning of year	783,890	718,064
Additional plan assets at fair value resulting from new affiliations	77,608	-
Total fair value of plan assets at beginning of year	861,498	718,064
Actual return on plan assets	25,473	112,218
Benefits paid	(34,803)	(31,467)
Expenses paid	(139)	-
Employer contributions	38,002	37,050
Settlements	(44,979)	(51,975)
Fair value of plan assets at end of year	845,052	783,890
Funded status of the plans	(143,091)	(93,192)
Current portion of liability for pension	(2,758)	(46)
Long term portion of liability for pension	(140,333)	(93,146)
Liability for pension	$ (143,091)	$ (93,192)

For the years ended June 30, 2015 and 2014 the liability for pension is included in the liability for pension and other postretirement plan benefits in the accompanying consolidated balance sheets.

Amounts not yet reflected in net periodic pension expense and included in the change in unrestricted net assets as of June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Net actuarial loss	$ 368,959	$ 311,084
Prior service cost	608	989
	$ 369,567	$ 312,073

The estimated amounts that will be amortized from unrestricted net assets into net periodic pension expense in 2016 are as follows:

(in thousands of dollars)	
Unrecognized prior service cost	$ 380
Net actuarial loss	26,098
	$ 26,478

The accumulated benefit obligation for the defined benefit pension plans was approximately $971,193,000 and $856,673,000 at June 30, 2015 and 2014, respectively.

The following table sets forth the assumptions used to determine the benefit obligation at June 30, 2015 and 2014:

	2015	2014
Weighted average discount rate	4.90 % - 5.00 %	4.90 %
Rate of increase in compensation	Age Graded/0.00 % - 2.50 %	Age Graded
Expected long-term rate of return on plan assets	7.50 % - 7.75 %	7.75 %

The primary investment objective for the Plan's assets is to support the Pension liabilities of the Pension Plans for Employees of the Health System, by providing long-term capital appreciation and by also using a Liability Driven Investing ("LDI") strategy to partially hedge the impact fluctuating interest rates have on the value of the Plan's liabilities. As of June 30, 2015 and 2014, it is expected that the LDI strategy will hedge approximately 65% and 70%, respectively, of the interest rate risk associated with pension liabilities. To achieve the appreciation and hedging objectives, the Plans utilize a diversified structure of asset classes designed to achieve stated performance objectives measured on a total return basis, which includes income plus realized and unrealized gains and losses.

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

	Range of Target Allocations	Target Allocations
Cash and short-term investments	0–5 %	2 %
U.S. government securities	0–5	1
Domestic debt securities	20–58	42
Global debt securities	6–26	10
Domestic equities	5–35	18
International equities	5–15	10
Emerging market equities	3–13	5
REIT Funds	0–5	-
Private equity funds	0–5	-
Hedge funds	5–18	12

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

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

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

The hierarchy and inputs to valuation techniques to measure fair value of the Plans' assets are the same as outlined in Note 7. In addition, the estimation of fair value of investments in private equity and hedge funds for which the underlying securities do not have a readily determinable value is made using the NAV per share or its equivalent as a practical expedient. The Health System's Plans own interests in these funds rather than in securities underlying each fund and, therefore, are generally required to consider such investments as Level 2 or Level 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, 2015 and 2014:

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

	2014					
(in thousands of dollars)	Level 1	Level 2	Level 3	Total	Redemption or Liquidation	Days' Notice
Investments						
Cash and short-term investments	$ 7,205	$ 51,347	$ -	$ 58,552	Daily	1
Domestic debt securities	74,388	241,679	-	316,067	Daily–Monthly	1–15
Global debt securities	39,591	46,151	-	85,742	Daily–Monthly	1–15
Domestic equities	131,761	10,390	-	142,151	Daily–Monthly	1–10
International equities	-	77,262	-	77,262	Daily–Monthly	1–11
Emerging market equities	-	41,537	-	41,537	Daily–Monthly	1–17
Private equity funds	-	-	3,944	3,944	See Note 7	See Note 7
Hedge funds	-	30,169	28,466	58,635	Quarterly–Annual	60–96
Total investments	$ 252,945	$ 498,535	$ 32,410	$ 783,890		

The following table presents additional information about the changes in Level 3 assets measured at fair value for the years ended June 30, 2015 and 2014:

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

	2014		
(in thousands of dollars)	Hedge Funds	Private Equity Funds	Total
Balances at beginning of year	$ 26,449	$ 12,761	$ 39,210
Purchases	-	6	6
Sales	(709)	(9,220)	(9,929)
Net realized (losses) gains	(59)	1,470	1,411
Net unrealized gains	2,785	(1,073)	1,712
Balances at end of year	$ 28,466	$ 3,944	$ 32,410

The total aggregate net unrealized gains (losses) included in the fair value of the Level 3 investments as of June 30, 2015 and 2014 were approximately $5,234,000 and $7,187,000, respectively. There were no transfers into and out of Level 3 measurements during the years ended June 30, 2015 and 2014.

There were no transfers into and out of Level 1 and Level 2 measurements due to changes in valuation methodologies during the years ended June 30, 2015 and 2014.

The weighted average asset allocation for the Health System's Plans at June 30, 2015 and 2014 by asset category is as follows:

	2015	2014
Cash and short-term investments	5 %	7 %
Domestic debt securities	39	40
Global debt securities	10	11
Domestic equities	20	18
International equities	11	10
Emerging market equities	5	5
Private equity funds	-	1
Hedge funds	10	8
	100 %	100 %

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.75% per annum.

The Health System is expected to contribute approximately $37,000,000 to the Plans in 2016.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid for the year ending June 30, 2016 and thereafter:

(in thousands of dollars)	Pension Plans
2016	$ 37,716
2017	40,158
2018	43,006
2019	46,233
2020	49,955
2021-2025	299,954

Defined Contribution Plans
The Health System has an employer-sponsored 401(a) plan for certain of its affiliates, under which the employer makes base, transition and discretionary match contributions based on specified percentages of compensation and employee deferral amounts. Total employer contributions to the plan of $30,204,000 and $33,068,000 in 2015 and 2014, respectively, are included in employee benefits in the accompanying consolidated statements of operations and changes in net assets.

The Health System also has available to employees of certain affiliates various 403(b) and tax-sheltered annuity plans in which they can participate. Plan specifications vary by affiliate and plan. No employer contributions were made to any of these plans in 2015 and 2014, 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 cost is comprised of the components listed below for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Service cost	$ 527	$ 1,803
Interest cost	2,347	4,411
Amortization of net transition asset	-	7
	$ 2,874	$ 6,221

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, 2015 and 2014:

(in thousands of dollars)	2015	2014
Change in benefit obligation		
Benefit obligation at beginning of year	$ 51,006	$ 84,538
Additional benefit obligation resulting from new affiliations	471	-
	51,477	84,538
Service cost	527	1,803
Interest cost	2,347	4,411
Benefits paid	(5,236)	(5,770)
Actuarial loss	1,323	5,450
Plan amendments	-	(39,426)
Benefit obligation at end of year	50,438	51,006
Funded status of the plans	(50,438)	(51,006)
Current portion of liabiality for postretirement medical and life benefits	(3,203)	(5,096)
Long term portion of liability for postretirement medical and life benefits	(47,235)	(45,910)
Liability for postretirement medical and life benefits	$ (50,438)	$ (51,006)

The plan amendments are primarily related to the Board's decision to offer retiree health care benefits to certain affiliates post-65 retirees and covered post-65 dependents through a private Medicare exchange beginning in April 2015.

For the years ended June 30, 2015 and 2014 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 cost and included in the change in unrestricted net assets are as follows:

(in thousands of dollars)	2015	2014
Net prior service (credit) cost	$ (33,452)	$ (39,426)
Net actuarial loss (gain)	10,260	9,559
	$ (23,192)	$ (29,867)

The estimated amounts that will be amortized from unrestricted net assets into net periodic postretirement expense in 2015 and 2014 are as follows:

(in thousands of dollars)	2015	2014
Net prior service (credit) cost	$ (5,974)	$ (5,974)
Net loss (gain)	610	513
	$ (5,364)	$ (5,461)

In determining the accumulated postretirement medical and life benefit obligation, the Health System used a discount rate of 4.7% in 2015 and an assumed healthcare cost trend rate of 7.25%, trending down to 4.75% in 2020 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, 2015 and 2014 by $4,479,000 and $4,411,000 and the net periodic postretirement medical benefit cost for the years then ended by $275,000 and $576,000, 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, 2015 and 2014 by $3,790,000 and $3,759,000 and the net periodic postretirement medical benefit cost for the years then ended by $233,000 and $649,000, respectively.

12. Professional and General Liability Insurance Coverage

D-H, along with Dartmouth College and The Cheshire Medical Center are provided professional and general liability insurance on a claims-made basis through Hamden Assurance Risk Retention Group, Inc. (RRG), a Vermont captive insurance company. RRG reinsures the majority of this risk to Hamden Assurance Company Limited (HAC), a captive insurance company domiciled in Bermuda and to a variety of commercial reinsurers. D-H and Dartmouth College have ownership interests in both HAC and RRG. The insurance program provides coverage to the covered institutions and named insureds on a modified claims-made basis which means coverage is triggered when claims are made. Premiums and related insurance deposits are actuarially determined based on asserted liability claims adjusted for future development. The reserves for outstanding losses are recorded on an undiscounted basis.

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

Selected financial data of HAC and RRG, taken from the latest available audited and unaudited financial statements, respectively at June 30, 2015 and 2014 are summarized as follows:

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

	2014		
	HAC	RRG	Total
(in thousands of dollars)	*(audited)*	*(audited)*	
Assets	$ 104,644	$ 1,880	$ 106,524
Shareholders' equity	13,620	569	14,189
Net income	-	26	26

13. Commitments and Contingencies

Litigation

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

Operating Leases and Other Commitments

The Health System leases certain facilities and equipment under operating leases with varying expiration dates. The Health System's rental expense totaled approximately $10,215,000 and $9,925,000 for the years ended June 30, 2015 and 2014, respectively. Minimum future lease payments under non-cancelable operating leases at June 30, 2015 were as follows:

(in thousands of dollars)	
2016	$ 8,272
2017	5,774
2018	3,971
2019	2,583
2020	939
Thereafter	722
	$ 22,261

Line 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 $60,000,000. Interest is variable and determined using LIBOR or the Wall Street Journal Prime Rate. The Loan Agreements are due to expire ranging from December 31, 2015 through May 31, 2016. The Health System has outstanding balances under the lines of credits in the amount of $1,200,000 and $0 at June 30, 2015 and 2014, respectively. Interest expense was approximately $193,000 and $185,000, respectively, and is included in the consolidated statements of operations and changes in net assets.

14. Functional Expenses

Operating expenses of the Health System by function are as follows for the years ended June 30, 2015 and 2014:

(in thousands of dollars)	2015	2014
Program services	$ 1,335,316	$ 1,192,696
Management and general	225,983	172,626
Fundraising	8,037	8,122
	$ 1,569,336	$ 1,373,444

15. Subsequent Events

The Health System has assessed the impact of subsequent events through November 27, 2015, 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.

Through the DHOG, issued NHHEFA Revenue Bonds, Series 2015A in September 2015 through a private placement with a financial institution. The Series 2015A Revenue Bonds were primarily used to refinance a portion of the Series 2011 Revenue Bonds. The Series 2015A Revenue Bonds accrue interest variably and mature at various dates through 2032.

Consolidating Supplemental Information

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

(in thousands of dollars)	D-HH (parent)	D-H and Subsidiaries	Cheshire and Subsidiaries	NLH and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Assets							
Current assets							
Cash and cash equivalents	$ 388	$ 9,279	$ 16,525	$ 7,612	$ 5,105	$ -	$ 38,909
Patient accounts receivable, net	-	177,287	14,053	7,388	5,544	-	204,272
Prepaid expenses and other current assets	11,574	102,954	7,921	3,632	2,616	(28,111)	100,586
Total current assets	11,962	289,520	38,499	18,632	13,265	(28,111)	343,767
Assets limited as to use	-	570,057	23,302	13,412	13,654	-	620,425
Other investments for restricted activities	-	113,117	18,899	-	-	-	132,016
Property, plant, and equipment, net	618	461,044	82,793	37,597	19,303	-	601,355
Other assets	4,263	66,837	10,130	5,451	3,903	(2,134)	88,450
Total assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013
Liabilities and Net Assets							
Current liabilities							
Current portion of long-term debt	$ -	$ 15,196	$ 952	$ 661	$ 370	$ -	$ 17,179
Line of credit	-	-	-	-	1,200	-	1,200
Current portion of liability for pension and other postretirement plan benefits	-	3,249	2,712	-	-	-	5,961
Accounts payable and accrued expenses	15,708	104,697	20,024	3,843	4,059	(28,110)	120,221
Accrued compensation and related benefits	-	85,064	4,936	2,373	2,491	-	94,864
Estimated third-party settlements	-	26,961	-	6,755	2,883	-	36,599
Total current liabilities	15,708	235,167	28,624	13,632	11,003	(28,110)	276,024
Long-term debt, excluding current portion	-	518,799	28,083	18,020	10,582	-	575,484
Insurance deposits and related liabilities	-	62,356	-	-	-	-	62,356
Interest rate swaps	-	20,937	-	3,531	272	-	24,740
Liability for pension and other postretirement plan benefits, excluding current portion	-	175,948	5,662	-	5,958	-	187,568
Other liabilities	-	51,303	3,671	1,135	-	-	56,109
Total liabilities	15,708	1,064,510	66,040	36,318	27,815	(28,110)	1,182,281
Net assets							
Unrestricted	1,135	346,900	79,700	34,227	14,367	(2,135)	474,194
Temporarily restricted	-	56,751	17,330	326	2,050	-	76,457
Permanently restricted	-	32,414	10,553	4,221	5,893	-	53,081
Total net assets	1,135	436,065	107,583	38,774	22,310	(2,135)	603,732
Commitments and contingencies							
Total liabilities and net assets	$ 16,843	$ 1,500,575	$ 173,623	$ 75,092	$ 50,125	$ (30,245)	$ 1,786,013

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

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Assets					
Current assets					
Cash and cash equivalents	$ 8,252	$ 182	$ 845	$ -	$ 9,279
Patient accounts receivable, net	177,287	-	-	-	177,287
Prepaid expenses and other current assets	102,425	338	438	(247)	102,954
Total current assets	287,964	520	1,283	(247)	289,520
Assets limited as to use	570,057	-	-	-	570,057
Other investments for restricted activities	89,176	23,941	-	-	113,117
Property, plant, and equipment, net	458,368	1	2,675	-	461,044
Other assets	66,675	3	159	-	66,837
Total assets	$ 1,472,240	$ 24,465	$ 4,117	$ (247)	$ 1,500,575
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 15,196	$ -	$ -	$ -	$ 15,196
Current portion of liability for pension and other postretirement plan benefits	3,249	-	-	-	3,249
Accounts payable and accrued expenses	102,666	1,536	742	(247)	104,697
Accrued compensation and related benefits	85,064	-	-	-	85,064
Estimated third-party settlements	26,961	-	-	-	26,961
Total current liabilities	233,136	1,536	742	(247)	235,167
Long-term debt, excluding current portion	518,799	-	-	-	518,799
Insurance deposits and related liabilities	62,356	-	-	-	62,356
Interest rate swaps	20,937	-	-	-	20,937
Liability for pension and other postretirement plan benefits, excluding current portion	175,948	-	-	-	175,948
Other liabilities	51,303	-	-	-	51,303
Total liabilities	1,062,479	1,536	742	(247)	1,064,510
Net assets					
Unrestricted	329,168	14,517	3,215	-	346,900
Temporarily restricted	50,297	6,294	160	-	56,751
Permanently restricted	30,296	2,118	-	-	32,414
Total net assets	409,761	22,929	3,375	-	436,065
Commitments and contingencies					
Total liabilities and net assets	$ 1,472,240	$ 24,465	$ 4,117	$ (247)	$ 1,500,575

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Balance Sheets
June 30, 2014

(in thousands of dollars)	D-HH (parent)	D-H and Subsidiaries	NLH and Subsidiaries	Eliminations	Health System Consolidated
Assets					
Current assets					
Cash and cash equivalents	$ 377	$ 46,371	$ 4,179	$ -	$ 50,927
Patient accounts receivable, net	-	178,066	6,540	-	184,606
Prepaid expenses and other current assets	4,503	92,807	2,907	(8,915)	91,302
Total current assets	4,880	317,244	13,626	(8,915)	326,835
Assets limited as to use	-	618,393	10,792	-	629,185
Other investments for restricted activities	-	101,675	-	-	101,675
Property, plant, and equipment, net	534	445,118	39,101	-	484,753
Other assets	3,213	62,960	7,870	(1,535)	72,508
Total assets	$ 8,627	$ 1,545,390	$ 71,389	$ (10,450)	$ 1,614,956
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ -	$ 12,487	$ 794	$ -	$ 13,281
Current portion of liability for pension and other postretirement plan benefits	-	5,142	-	-	5,142
Accounts payable and accrued expenses	9,623	89,408	2,907	(8,915)	93,023
Accrued compensation and related benefits	-	76,407	2,168	-	78,575
Estimated third-party settlements	-	25,103	5,574	-	30,677
Total current liabilities	9,623	208,547	11,443	(8,915)	220,698
Long-term debt, excluding current portion	-	532,336	18,367	-	550,703
Insurance deposits and related liabilities	-	68,498	-	-	68,498
Interest rate swaps	-	21,103	3,310	-	24,413
Liability for pension and other postretirement plan benefits, excluding current portion	-	139,056	-	-	139,056
Other liabilities	-	46,568	1,412	-	47,980
Total liabilities	9,623	1,016,108	34,532	(8,915)	1,051,348
Net assets					
Unrestricted	(996)	432,909	32,297	(1,535)	462,675
Temporarily restricted	-	64,346	318	-	64,664
Permanently restricted	-	32,027	4,242	-	36,269
Total net assets	(996)	529,282	36,857	(1,535)	563,608
Commitments and contingencies					
Total liabilities and net assets	$ 8,627	$ 1,545,390	$ 71,389	$ (10,450)	$ 1,614,956

Dartmouth-Hitchcock and Subsidiaries
Consolidating Balance Sheets
June 30, 2014

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Assets					
Current assets					
Cash and cash equivalents	$ 45,438	$ 213	$ 720	$ -	$ 46,371
Patient accounts receivable, net	178,066	-	-	-	178,066
Prepaid expenses and other current assets	92,372	171	496	(232)	92,807
Total current assets	315,876	384	1,216	(232)	317,244
Assets limited as to use	618,393	-	-	-	618,393
Other investments for restricted activities	77,622	24,053	-	-	101,675
Property, plant, and equipment, net	442,441	2	2,675	-	445,118
Other assets	62,791	10	159	-	62,960
Total assets	$ 1,517,123	$ 24,449	$ 4,050	$ (232)	$ 1,545,390
Liabilities and Net Assets					
Current liabilities					
Current portion of long-term debt	$ 12,487	$ -	$ -	$ -	$ 12,487
Current portion of liability for pension and other postretirement plan benefits	5,142	-	-	-	5,142
Accounts payable and accrued expenses	87,663	1,304	673	(232)	89,408
Accrued compensation and related benefits	76,407	-	-	-	76,407
Estimated third-party settlements	25,103	-	-	-	25,103
Total current liabilities	206,802	1,304	673	(232)	208,547
Long-term debt, excluding current portion	532,336	-	-	-	532,336
Insurance deposits and related liabilities	68,498	-	-	-	68,498
Interest rate swaps	21,103	-	-	-	21,103
Liability for pension and other postretirement plan benefits, excluding current portion	139,056	-	-	-	139,056
Other liabilities	46,568	-	-	-	46,568
Total liabilities	1,014,363	1,304	673	(232)	1,016,108
Net assets					
Unrestricted	415,333	14,358	3,218	-	432,909
Temporarily restricted	57,518	6,669	159	-	64,346
Permanently restricted	29,909	2,118	-	-	32,027
Total net assets	502,760	23,145	3,377	-	529,282
Commitments and contingencies					
Total liabilities and net assets	$ 1,517,123	$ 24,449	$ 4,050	$ (232)	$ 1,545,390

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

(in thousands of dollars)	D-HH (parent)	D-H and Subsidiaries	NLH and Subsidiaries	Cheshire and Subsidiaries	MAHHC and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support							
Net patient service revenue	$ -	$ 1,225,872	$ 56,356	$ 52,536	$ 46,102	$ (307)	$ 1,380,559
Contracted revenue	-	82,091	-	-	-	(1,256)	80,835
Other operating revenue	12,203	69,663	3,063	1,076	3,526	(6,538)	82,993
Net assets released from restrictions	-	15,314	111	212	-	-	15,637
Total unrestricted revenue and other support	12,203	1,392,940	59,530	53,824	49,628	(8,101)	1,560,024
Operating expenses							
Salaries	960	694,373	27,562	20,949	24,076	8,482	776,402
Employee benefits	263	194,619	5,764	5,724	6,112	1,493	213,975
Medical supplies and medications	139	201,451	5,910	8,712	3,736	19	219,967
Purchased services and other	17,448	168,029	13,206	13,535	11,888	(18,402)	205,704
Medicaid enhancement tax	-	45,839	1,941	2,363	1,853	-	51,996
Depreciation and amortization	75	56,649	4,075	3,436	2,978	-	67,213
Interest	-	16,781	849	357	455	-	18,442
Expenditures relating to net assets released from restrictions	-	15,314	111	212	-	-	15,637
Total operating expenses	18,885	1,393,055	59,418	55,288	51,098	(8,408)	1,569,336
Operating margin (loss)	(6,682)	(115)	112	(1,464)	(1,470)	307	(9,312)
Nonoperating gains (losses)							
Investment (losses) gains	-	(12,011)	625	311	60	-	(11,015)
Other, net	339	(2,880)	1,409	141	57	(307)	(1,241)
Contribution revenue from acquisition	92,499	-	-	-	-	-	92,499
Total nonoperating (losses) gains, net	92,838	(14,891)	2,034	452	117	(307)	80,243
(Deficiency) excess of revenue over expenses	86,156	(15,006)	2,146	(1,012)	(1,353)	-	70,931
Unrestricted net assets							
Net assets released from restrictions (Note 8)	-	717	5	1,010	679	-	2,411
Change in funded status of pension and other postretirement benefits	-	(62,977)	-	2,875	(790)	-	(60,892)
Net assets transferred (from) to affiliates	(84,626)	(7,873)	-	76,827	15,672	-	-
Additional paid in capital	600		-	-	-	(600)	-
Change in fair value on interest rate swaps	-	(869)	(221)	-	159	-	(931)
(Decrease) increase in unrestricted net assets	$ 2,130	$ (86,008)	$ 1,930	$ 79,700	$ 14,367	$ (600)	$ 11,519

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

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,225,874	$ -	$ -	$ (2)	$ 1,225,872
Contracted revenue	81,474	847	-	(230)	82,091
Other operating revenue	64,928	2,356	6,482	(4,103)	69,663
Net assets released from restrictions	14,610	704	-	-	15,314
Total unrestricted revenue and other support	1,386,886	3,907	6,482	(4,335)	1,392,940
Operating expenses					
Salaries	693,407	-	-	966	694,373
Employee benefits	194,467	-	-	152	194,619
Medical supplies and medications	201,458	-	-	(7)	201,451
Purchased services and other	160,088	3,375	6,484	(1,918)	168,029
Medicaid enhancement tax	45,839	-	-	-	45,839
Depreciation and amortization	56,649	-	-	-	56,649
Interest	16,781	-	-	-	16,781
Expenditures relating to net assets released from restrictions	14,610	704	-	-	15,314
Total operating expenses	1,383,299	4,079	6,484	(807)	1,393,055
Operating margin (loss)	3,587	(172)	(2)	(3,528)	(115)
Nonoperating gains (losses)					
Investment (losses) gains	(12,079)	68	-	-	(12,011)
Other, net	(6,408)	-	-	3,528	(2,880)
Total nonoperating (losses) gains, net	(18,487)	68	-	3,528	(14,891)
(Deficiency) excess of revenue over expenses	(14,900)	(104)	(2)	-	(15,006)
Unrestricted net assets					
Net assets released from restrictions (Note 8)	454	263	-	-	717
Change in funded status of pension and other postretirement benefits	(62,977)	-	-	-	(62,977)
Net assets transferred (from) to affiliates	(7,873)	-	-	-	(7,873)
Change in fair value on interest rate swaps	(869)	-	-	-	(869)
(Decrease) increase in unrestricted net assets	$ (86,165)	$ 159	$ (2)	$ -	$ (86,008)

Dartmouth-Hitchcock Health and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2014

(in thousands of dollars)	D-HH (parent)	D-H and Subsidiaries	NLH and Subsidiaries	Eliminations	Health System Consolidated
Unrestricted revenue and other support					
Net patient service revenue	$ -	$ 1,190,366	$ 39,482	$ -	$ 1,229,848
Contracted revenue	1,004	91,386	-	-	92,390
Other operating revenue	2,435	62,399	2,161	(2,191)	64,804
Net assets released from restrictions	-	11,576	94	-	11,670
Total unrestricted revenue and other support	3,439	1,355,727	41,737	(2,191)	1,398,712
Operating expenses					
Salaries	1,071	651,038	21,070	2,537	675,716
Employee benefits	311	203,388	4,783	570	209,052
Medical supplies and medications	-	188,885	7,512	-	196,397
Purchased services and other	7,702	162,069	5,897	(5,712)	169,956
Medicaid enhancement tax	-	32,636	1,852	-	34,488
Depreciation and amortization	103	54,915	2,711	-	57,729
Interest	-	17,777	659	-	18,436
Expenditures relating to net assets					-
released from restrictions	-	11,576	94	-	11,670
Total operating expenses	9,187	1,322,284	44,578	(2,605)	1,373,444
Operating margin	(5,748)	33,443	(2,841)	414	25,268
Nonoperating gains (losses)					
Investment gains	(267)	55,927	1,144	-	56,804
Other, net	333	(4,679)	287	(414)	(4,473)
Contribution revenue from acquisition	33,692	-	-	-	33,692
Total nonoperating gains, net	33,758	51,248	1,431	(414)	86,023
Excess (deficiency) of revenue over expenses	28,010	84,691	(1,410)	-	111,291
Unrestricted net assets					
Net assets released from restrictions (Note 8)	-	748	15	-	763
Change in funded status of pension and other					-
postretirement benefits	-	19,669	-	-	19,669
Net assets transferred to affiliate	(29,257)	(4,435)	33,692	-	-
Additional paid in capital	1,348	-	-	(1,348)	-
Change in fair value on interest rate swaps	-	1,538	-	-	1,538
Increase (decrease) in unrestricted net assets	$ 101	$ 102,211	$ 32,297	$ (1,348)	$ 133,261

Dartmouth-Hitchcock and Subsidiaries
Consolidating Statements of Operations and Changes in Unrestricted Net Assets
Year Ended June 30, 2014

(in thousands of dollars)	D-H Obligated Group	THF	DHMC	Eliminations	D-H and Subsidiaries
Unrestricted revenue and other support					
Net patient service revenue	$ 1,190,366	$ -	$ -	$ -	$ 1,190,366
Contracted revenue	91,034	710	-	(358)	91,386
Other operating revenue	57,306	1,704	6,933	(3,544)	62,399
Net assets released from restrictions	10,274	1,302	-	-	11,576
Total unrestricted revenue and other support	1,348,980	3,716	6,933	(3,902)	1,355,727
Operating expenses					
Salaries	649,981	-	-	1,057	651,038
Employee benefits	203,259	-	-	129	203,388
Medical supplies and medications	188,905	-	-	(20)	188,885
Purchased services and other	154,908	2,816	6,934	(2,589)	162,069
Medicaid enhancement tax	32,636	-	-	-	32,636
Depreciation and amortization	54,894	-	21	-	54,915
Interest	17,777	-	-	-	17,777
Expenditures relating to net assets released from restrictions	10,274	1,302	-	-	11,576
Total operating expenses	1,312,634	4,118	6,955	(1,423)	1,322,284
Operating margin	36,346	(402)	(22)	(2,479)	33,443
Nonoperating gains (losses)					
Investment gains	53,398	2,529	-	-	55,927
Other, net	(7,158)	-	-	2,479	(4,679)
Total nonoperating gains, net	46,240	2,529	-	2,479	51,248
Excess (deficiency) of revenue over expenses	82,586	2,127	(22)	-	84,691
Unrestricted net assets					
Net assets released from restrictions (Note 8)	485	263	-	-	748
Change in funded status of pension and other postretirement benefits	19,669	-	-	-	19,669
Net assets transferred to affiliate	(4,435)	-	-	-	(4,435)
Change in fair value on interest rate swaps	1,538	-	-	-	1,538
Increase (decrease) in unrestricted net assets	$ 99,843	$ 2,390	$ (22)	$ -	$ 102,211

DARTMOUTH-HITCHCOCK (D-H)
DARTMOUTH-HITCHCOCK HEALTH (D-HH)

BOARDS OF TRUSTEES AND OFFICERS

(19 Total Trustees)

Effective: January 1, 2016

Troyen A. Brennan, MD, MPH (Wendy Warring) MHMH/DHC/D-HH Trustee *Executive Vice President and* *Chief Medical Officer of CVS Health*	MHMH/DHC: Elected on 3/20/2015. Term began 4/1/2015. Full term expires 12/31/2023. D-HH: Elected on 3/20/2015 as a DHC rep.
R. William Burgess, Jr. (Barbara) MHMH/DHC/D-HH Trustee *Managing Partner, ABS Ventures*	MHMH/DHC: Elected on 12/5/2014. Term began 1/1/2015. Full term expires 12/31/2023. D-HH: Elected on 9/19/2014 to complete Bill Helman's term as DC rep through 12/31/2014 and to begin his own 4 yr term on 1/1/2015 (ending 12/31/2018).
Jeffrey A. Cohen, MD (Renee Vebell) MHMH/DHC Trustee *Chair, Dept. of Neurology*	MHMH/DHC: Elected on 12/4/2015. Term began 1/1/2016. Full term expires 12/31/2018.
Duane A. Compton, PhD MHMH/DHC/D-HH Trustee *Ex-Officio: Interim Dean, Geisel School of Medicine at Dartmouth*	MHMH/DHC/D-HH: Ex-officio (effective 7/15/2014).

William J. Conaty (Sue) MHMH/DHC/D-HH Trustee *President, Conaty Consulting, LLC*	MHMH/DHC: Term began 6/1/2011. Full term expires 5/31/2020. D-HH: Elected DHC rep. trustee (on 12/9/11) effective 1/1/2012.
Vincent S. Conti (Meredith) MHMH/DHC/D-HH Trustee *Retired President & CEO, Maine Medical Center*	MHMH/DHC: President appointed to MHMH Aug-Dec 2009. Nominated to both MHMH/DHC on 8/13/09 for a term to start 1/1/2010. Full term expires 12/31/2018. D-HH: Elected 12/2/09 as an MHMH rep.
Denis A. Cortese, MD (Donna) MHMH/DHC/D-HH Trustee *Foundation Professor at Arizona State University (ASU) and Director of ASU's Healthcare Delivery and Policy Program*	MHMH: President appointed to MHMH effective 9/1/2012 (approved by the BoT 6/15/12). Nominated to both MHMH/DHC on 12/7/12 for a term to start 1/1/2013. Full term expires 12/31/2021. D-HH: Elected on 3/15/13 as an MHMH rep.
Barbara J. Couch (Richard) MHMH/DHC/D-HH Boards' Secretary *President of Hypertherm's HOPE Foundation (includes leadership of all of Hypertherm's philanthropic and volunteer initiatives)*	MHMH/DHC: Nominated on 3/25/09; completed D. Weaver's term through 12/31/09. Full term began 1/1/2010. Full term expires 12/31/2018. D-HH: Elected DHC rep.

Paul P. Danos, PhD (Mary Ellen) MHMH/DHC/D-HH Trustee *Dean Emeritus; Laurence F. Whittemore Professor of Business Administration, Tuck School of Business at Dartmouth*	MHMH/DHC: Elected 2/5/2014 for a term beginning immediately. Term expires 12/31/2016. Full term expires 5/31/2022. D-HH: Elected DHC rep. trustee (on 2/5/2014) effective immediately.
Senator Judd A. Gregg (Kathleen) MHMH/DHC Trustee *Senior Advisor to SIFMA*	MHMH/DHC: Term began 1/1/2013. Full term expires 12/31/2021.
M. Brooke Herndon, MD (Eric Miller) MHMH/DHC (Lebanon Physician) Trustee *Staff Physician, Primary Care, DHMC (Heater Road)*	D-H: Elected on 3/20/2015 for a 3 year term that began 1/1/2015 and end 12/31/ 2017.
Barbara C. Jobst, MD (Markus) MHMH/DHC (Lebanon Physician) Trustee *Section Chief of Adult Neurology at DHMC and Director of the Dartmouth-Hitchcock Epilepsy Center*	D-H: Elected on 12/6/2013 for a 3 year term to begin 1/1/2014 and end 12/31/ 2016.
Laura K. Landy (Robert Corman) MHMH/DHC/D-HH Trustee *President and CEO of the Fannie E. Rippel Foundation*	MHMH: President appointed to MHMH effective 9/1/2012 (approved by the BoT 6/15/12). Nominated to both MHMH/DHC on 12/7/12 for a term to start 1/1/2013. Full term expires 12/31/2021. D-HH: Elected on 3/15/13 as an MHMH rep.

Robert A. Oden, Jr., PhD (Teresa) MHMH/DHC/D-HH Boards' Vice Chair *Retired President, Carleton College*	MHMH/DHC: President appointee to MHMH (1/27/11 - 12/31/11). Elected to MHMH/DHC Boards on 12/9/11 for a term 1/1/2012 - 12/31/2014. Full term expires 12/31/2020. Became Board Chair 1/1/2013. Term expired 12/31/15. Vice-Chair: 1/1/16 D-HH: Elected DHC rep. trustee (on 12/9/11) effective 1/1/2012.
Charles G. Plimpton (Barbara Nyholm) MHMH/DHC/D-HH Boards' Treasurer *Retired Investment Banker*	MHMH/DHC: Elected on 3/20/2015. Term began 4/1/2015. Full term expires 12/31/2023. Board Treasurer: 1/1/16 D-HH: Elected on 3/20/2015 as an MHMH rep.
Timothy D. Scherer, MD MHMH/DHC Trustee *Associate Medical Director of Specialty Services, D-H Nashua*	MHMH/DHC: Elected on 12/4/2015. Term began 1/1/2016. Full term expires 12/31/2018.
Brian C. Spence, MD, MHCDS (Kirsten Glass, VMD) MHMH/DHC Trustee *Associate Professor of Anesthesiology*	MHMH/DHC: Elected on 12/4/2015. Term began 1/1/2016. Full term expires 12/31/2018.

Anne-Lee Verville MHMH/DHC/D-HH Boards' Chair *Retired senior executive, IBM*	MHMH/DHC: Completed Fuehrer's term through 12/31/08. Nominated on 12/17/08. Term began 1/1/2009. Full term expires 12/31/2017. D-HH: Elected 9/3/10 as an MHMH rep. trustee. Re-elected on 12/6/2013 as a DHC rep for a term to end on 12/31/2015. Re-elected as MHMH rep on 12/4/15. Vice-Chair effective 10/1/2014. Board Chair eff: 1/1/16
James N. Weinstein, DO, MS (Mimi) MHMH/DHC/D-HH Trustee *Ex-officio: CEO, Dartmouth-Hitchcock; President, D-HH*	MHMH/DHC/D-HH: Ex-officio as DHC President effective 1/14/2010. Ex-officio as CEO of D-H began 11/1/2011. Voted by the D-HH Board as President on 9/1/2012 or upon vacancy. Became President on 11/14/2011 when Dr. Colacchio resigned.

Member of D-HH, not a member of D-H:

Steven "Steve" A. Paris, MD (Susan) **D-HH Trustee**	D-HH: elected to the Board on 6/28/13 for a term to begin immediately and end on 12/31/2015. Elected on 12/4/2015 for a term effective as of 1/1/2016 as a Physician Rep. (NOTE: Term expired on D-H Board 12/31/2015)

Administrative Support:
Kimberley A. Gibbs (603/650-8779)
Director, Governance & Leadership
One Medical Center Drive, Lebanon, NH 03756
kimberley.a.gibbs@hitchcock.org
Fax: 603/650-7440

Claire M. Lillie (603/650-5244)
Exec. Coordinator for Governance & Leadership
claire.m.lillie@hitchcock.org

Susan Gingerich, MSW

EDUCATION

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

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

PROFESSIONAL POSITIONS

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

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

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

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

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

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

12/88-1/91 New York State Psychiatric Institute, New York, New York.
Supervisor/consultant for Multiple Family Education groups, conducted as part of Family Support Demonstration Project (William McFarlane, MD).

12/87-7/89 Hillside Hospital, Long Island Jewish Medical Center, Glen Oaks, New York.
Mt. Sinai Hospital, New York, New York.
Research clinician for Post-Psychotic Depression Study (Sam Siris, MD).

PUBLICATIONS

2013 Mueser, K.T., Gottlieb, J.D., & Gingerich, S. Social skills and problem solving training. In S.G. Hoffman (Ed.), Wiley Handbook of Cognitive Behavioral Therapy (pp. 243-271). New York: Wiley.

2013 Mueser, K.T., & Gingerich, S. Treatment of co-occurring psychotic and substance use disorders. Social Work in Public Health, 28, 424-39.

2011 Mueser, K.T., & Gingerich, S. Relapse prevention and recovery in patients with psychosis: The role of psychiatric rehabilitation. Psychiatric Times, 28(6), 66-71.

2011 Mueser, K., & Gingerich, S. Collaborating with Families of People with Serious Mental Illness. In Rudnick, A. and Roe, D. (Editors). Serious Mental Illness: Person-Centered Approaches. NY, NY: Radcliffe Publishing.

2011 Gingerich, S. & Mueser, K. Illness Management and Recovery: Personalized Skills and Strategies for Those with Mental Illness. (Client handouts, Practitioner Session-by-Session Guidelines, Implementation Guide, CD-ROM, DVD of introduction and practitioner training vignettes). Center City, MN: Hazelden Publications.

2011 Mueser, S. & Gingerich, S. Illness Management and Recovery. In Vandiver, V. (Ed.). Best Practices in Mental Health: A Pocket Guide. New York, NY: Oxford University Press.

2011 Mueser, K.T., & Gingerich, S. Illness self-management programmes. In G. Thornicroft, G. Szmukler, K.T. Mueser, & R.E. Drake (Eds.), Oxford Textbook of Community Mental Health. Oxford, England: Oxford University Press (pp. 211-219

2010 Meyer, P., Mueser, K. & Gingerich, S. A guide to implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, Springer, and Trawver (Eds.), Psychosocial treatment of Schizophrenia. New York, NY: Wiley.

279. Wojcik JD, Shindul-Rothschild J, Norris AE, Wolfe B, Stone W, Mesholam-Gately RI, Giuliano AJ, Green A, Seidman LJ, Keshavan M. Clinical Characteristics of People in Randomized Clinical Trials of Frist Episode Schizophrenia Spectrum Disorders: Attrition vs. Non-Attrition Groups. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 326.

280. Gamsby JJ, Gulick D, Templeton E, Wang W, Loros JJ, Dunlap JC, Green AI. The circadian Period genes modulate both alcohol drinking and the effects of clozapine on drinking behavior in mice. Program No. 164.11. 2011 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2011. Online.

281. Gulick D, Templeton E, Green AI. Delta-9-tetrahydrocannabinol decreases alcohol intake in the Syrian golden hamster. Program No. 427.04. 2011 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2011. Online.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

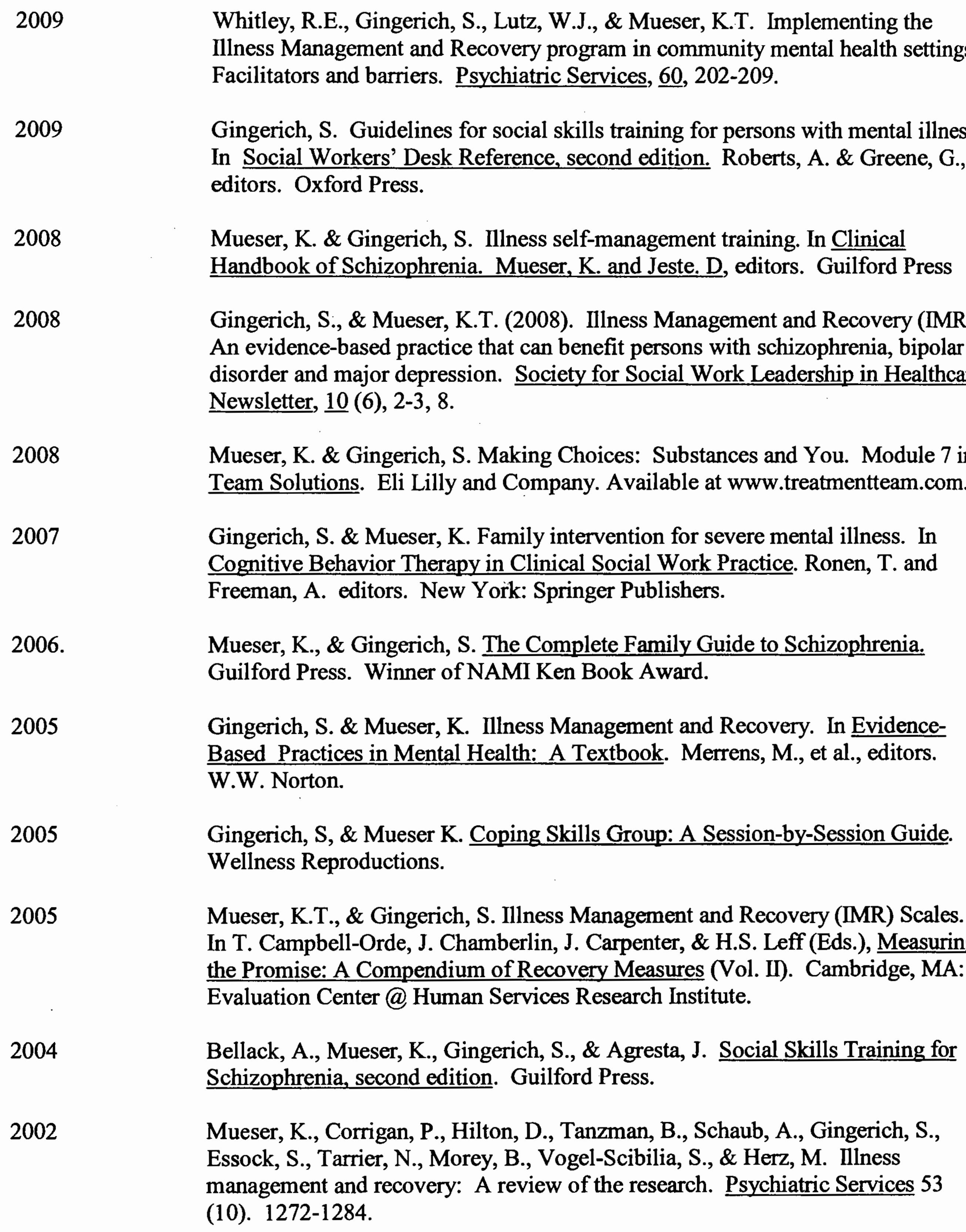
299. Fischer AS, Whitfield-Gabrieli S, Roth R, Green AI. Improvement in anti-correlation between regions of the "task positive" and defauilt mode and networks induced by cannabis and THC in patients with schizophrenia: Implications for working memory? International Congress on Schizophrenia Research,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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

MANUALS

2013	Gingerich, S., Meyer, P., & Mueser, K. Relapse Prevention Planning manual for the Health Technology Program (part of a grant from CMMI, the Center for Medicaid and Medicare Improvement)
2013	Gingerich, S., Miller, J., Monroe-Devita, M., Mors, G., Mueser, K., & Hamilton, A. ACT+IMR: Integrating Illness Management and Recovery into Assertive Community Treatment Teams.
2013	Meyer, P., Gingerich, S., Fox, L., & Mueser, K. Minnesota Clinical Competency Scale for Enhanced IMR for Co-occurring Disorders, First Edition.
2011	Overall co-editor and contributing author to the following RAISE-Early Treatment Program manuals: Individual Resiliency Training, Family Education Program, Supported Employment and Education, and Team Members' Guide.
2009	Gingerich, S., Arnold, K. & Mueser, K. The Happy, Healthy Life Group (an Adaptation of the Illness Management and Recovery Toolkit for Persons with Mental Illness and Intellectual Disabilities and/or Cognitive Challenges).
2007	Meyer, P., Gingerich, S., & Mueser, K. Minnesota IMR Clinical Competency Scale.
2006	Gingerich, S. & Agresta, J. Multiple Family Groups for Adolescents with Mood Disorders.
2002	Gingerich, S., & Mueser, K., Illness Management and Recovery: Implementation Toolkit . Substance Abuse and Mental Health Services Administration.
2001	Gingerich, S. Conducting Groups for Clients in an Inpatient Psychiatric Facility.
1994	Bellack, A., Gingerich, S., Agresta, J. & Mueser, K. Social Skills Training for Psychiatric Clients with Persistent Symptoms.
1991	Mueser, K., Gingerich, S. & Rosenthal, C. Educational Family Therapy.
1989	McFarlane, W., Deakins, S., Gingerich, S., Horen, B., & Newmark, M. Conducting Multiple Family Psychoeducational Groups.

CURRICULUM VITAE

Name: Alan Ivan Green, M.D.

Office Address: Department of Psychiatry, Geisel School of Medicine at Dartmouth

Postdoctoral Training

Internship and Residencies

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

Research Fellowships

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

Licensure and Certification

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

Faculty Academic Appointments

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

Hospital Appointments

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

Other Professional Positions and Major Visiting Appointments

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

Major Administrative Leadership Appointments

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

Committee Service

1983-1984	Vice President, Clinical Staff Organization, Massachusetts Mental Health Center
1984	President, Clinical Staff Organization, Massachusetts Mental Health Center

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

Professional Societies

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

Grant Review Activities

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

Editorial Activities

1995-2013	Member, Editorial Board, Harvard Mental Health Letter
2003-	Member, Editorial Board, Schizophrenia Research
2003-	Member, Editorial Board, The Journal of Dual Diagnosis
2008-	Associate Editor, The Journal of Dual Diagnosis
2008-2010	Member, Physician Editorial Board, Neuropsychiatry Reviews
2009-	Assistant Editor, Addiction
2010-2013	Member, Editorial Board, Schizophrenia Bulletin
2010-	Co-Editor, The Journal of Dual Diagnosis

Honors and Prizes

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

Major Research Interests

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

Research Funding

Current Federal Grants

2012-2017 NIDA R01DA032533 PI: Green	Clozapine for cannabis use disorder in schizophrenia
~~2013-2019~~ NIDA R01DA034699 PI: Green	~~Cannabis, schizophrenia and reward: self-medication and agonist~~ treatment?
2013-2018 NCATS 1 UL1 TR001086-01 NCATS 1KL2TR001088-01 PI: Green	Dartmouth SYNERGY| The Dartmouth Clinical and Translational Science Institute
2014-2015 NCATS 3UL1TR001086-02S2 PI: Green	Development of a Cross-CTSA IRB Reliance Program (National IRB Reliance Initiative)
2015- 2016 NIAAA/Fast-Track Drugs & Biologics PI: Green	Randomized, Double Blind, Placebo-Controlled Trial of the Safety and Efficacy of HORIZANT® (Gabapentin Enacarbil) Extended-Release Tablets for the Treatment of Alcohol Use Disorder

2015-2020 NIH/NIDA PI: Marsch/Poldrack	Applying Novel Technologies and Methods to Inform the Ontology of Self-Regulation

Current Clinical Trials: None

Current Investigator Initiated Grants from Industry:

2015-2016 Alkermes PI: Green	Olanzapine-Samidorphan in Alcohol-Preferring Rodents

Past NARSAD Grant:

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

Past Federal Grants

1993-2001 NIMH RO1MH49891 PI: Green	Clozapine response and biogenic amines in schizophrenia
1994-1999 NIMH RO1MH52376 PI: Green	Clozapine vs. haloperidol in first episode schizophrenia
1995-2001 NIMH RO1MH49891-Supp. PI: Green	Clozapine vs. olanzapine: an effectiveness study. Clinical Services Supplement to Grant #RO1MH49891
1995-1998 NIMH RO1MH49891-Supp. PI: Green	Minority Supplement to Grant #RO1MH49891
1999-2004 NIAAA RO1AA11904 PI: Green	Alcoholism and schizophrenia: Effects of clozapine
1999-2004 NIAAA RO1AA11904 PI: Green	Minority Supplement to NIAAA Grant #RO1AA11904
2004-2007 NIAAA R03AA014644 PI: Green	Antipsychotics and alcohol drinking in rodents
2000-2008 NIDA R01DA13196 PI: Green	Cannabis and schizophrenia: Effects of clozapine

2001-2009 NIMH R21MH62157 PI: Green	Clozapine, cannabis and first episode schizophrenia
2004-2009 NIDA R21DA019215-01 PI: Green	Cannabis and schizophrenia: fMRI Reward Circuit Biomarker
2007-2009 NIAAA CSP-1027 PI: Green	Efficacy of quetiapine fumarate sustained release for the treatment of alcohol dependency in very heavy drinkers
2007-2010 NIMH 5R03MH075833-02 PI: Chau; Co-PI: Green	Toward a Rat Model of Alcohol Abuse in Schizophrenia
2009-2011 NIAAA/Fast Track NCIG-002 PI: Green	Efficacy of Levetiracetam Extended Release for the treatment of alcohol dependency in very heavy drinkers
2009-2011 NIAAA R13AA018603 PI: Green	Conference: Integrating Etiologic Models and Optimizing Treatment for Alcohol Disorders in Schizophrenia Patients
2010-2012 NIDA R21 DA029131 PI: Sevy	Improving Substance Use and Clinical Outcomes in Heavy Cannabis Users
2011-2012 NIAAA/Fast Track NCIG-003 PI: Green	A Phase 2, Double-Blind, Placebo Controlled Trial to Assess the Efficacy of Varenicline Tartrate for Alcohol Dependence in Very Heavy Drinkers.
2009-2012 NIDA R01DA026799 PI: Green	Cannabis and Schizophrenia: Self-Medication and Agonist Treatment? (No Cost Extension)
2010-2013 NIAAA R01AA018151 PI: Green	Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia (No Cost Extension)
2011-2014 NIAAA R21AA019534 PI: Green	Alcoholism and Schizophrenia: A Translational Approach to Treatment (No Cost Extension)
2014-2015 NCATS 3UL1TR001086-02S1 PI: Green	Enhancing Clinical Research Professionals' Training and Qualifications

Past Investigator Initiated Grants

1989-1990 Milton Fund Harvard Medical School PI: Green	Subgroups of psychotic patients: pharmacologic, biochemical and clinical differences

1991-1994 Sandoz Research Institute PI: Green	Clozapine in psychotic patients
1993-1994 Eli Lilly & Co. PI: Green	Biochemical predictors and correlates of response to olanzapine
1994-1996 Otsuka America Pharm., Inc. PI: Green	Biochemical predictors and correlates of response to OPC-14597
1997-1999 Eli Lilly & Co. PI: Green	Olanzapine vs. typical neuroleptics: prolactin level and ovarian function
1997-1999 Novartis Pharmaceuticals PI: Green	Clozapine's effect on prolactin level and ovarian function
1997-2000 Janssen Research Foundation PI: Green (with MT Tsuang)	Risperidone in relatives of patients with schizophrenia
1997-2001 Eli Lilly & Co. PI: Green	Olanzapine vs. haloperidol in first episode schizophrenia: an addendum study
1999-1999 Novartis Pharmaceuticals PI: Green	Clozapine in patients with schizophrenia and substance abuse
1999-2003 Eli Lilly & Co. PI: Green	Clozapine vs. olanzapine: an effectiveness study
2000-2001 Eli Lilly & Co. PI: Green	Preventing weight gain from novel antipsychotics (feasibility study)
2001-2002 Novartis Pharmaceuticals PI: Green	Does clozapine limit alcohol drinking in Syrian Golden Hamsters?
2002-2006 AstraZeneca PI: Green	Comparison of atypical antipsychotics in first episode schizophrenia
2004-2006 Bristol-Myers Squibb/Otsuka PI: Green	Aripiprazole in alcohol drinking rodents
2000-2007	Quetiapine in schizophrenia and comorbid

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

Past Clinical Trials

1989-1991 Janssen Research Foundation PI: Green	Risperidone in the treatment of schizophrenia
1989-1990 Sandoz Research Institute PI: Green	SDZ HDC-912 in the treatment of schizophrenia
1991-1994 Merck, Sharp & Dome PI: Green	Remoxipride vs. haloperidol in schizophrenic outpatients
1993-1997 Eli Lilly & Co. PI: Green	Fixed-dose olanzapine vs. placebo in the treatment of schizophrenia
1994-1996 Otsuka America Pharm., Inc. PI: Green	OPC-14597 vs. haloperidol and placebo in the treatments of schizophrenia

1994-1996 Pfizer, Inc. PI: Green	Inpatient study of ziprasidone and haloperidol in the acute exacerbation of schizophrenia and schizoaffective disorder
1994-1996 Pfizer, Inc. PI: Green	Evaluating the safety and efficacy of two dose regimens of oral ziprasidone and haloperidol in the maintenance treatment of outpatients with schizophrenia or schizoaffective disorder
1994-2000 Pfizer, Inc. PI: Green	Evaluating the safety and outcome of oral ziprasidone in subjects who have participated in previous clinical trials of ziprasidone
1995-1996 Otsuka America Pharm., Inc. PI: Green	A dose ranging study of OPC-14597 in patients with schizophrenia
1995-2002 Otsuka America Pharm., Inc. PI: Green	An open-label tolerability study of OPC 14597 in schizophrenic patients
1996-1997 Zeneca Pharmaceuticals PI: Green	Health outcomes study of Seroquel and usual care in schizophrenia and schizoaffective disorder
1996-1998 Janssen Research Foundation PI: Green	A comparison of risperidone and haloperidol for prevention of relapse in subjects with schizophrenia and schizoaffective disorders
1997 ICON Clinical Research, Inc. PI: Green	A phase III randomized study comparing 2 doses of intramuscular ziprasidone (2 mg and 20 mg) in subjects with psychosis and acute agitation
1997-1998 Hoescht Marion Rousel, Inc. PI: Green	A multicenter, randomized, double-blind, placebo and active controlled study of MDL 100,907 in schizophrenic and schizoaffective patients
1997-1999 Hoescht Marion Rousel, Inc. PI: Green	A multicenter, open-label, long-term follow-up, safety study of MDL 100,907 in schizophrenic and schizoaffective patients
1997-1999 Otsuka America Pharm., Inc. PI: Green	A study of aripiprazole in schizophrenia
1997-2001 Eli Lilly & Co. PI: Green	The acute and long-term efficacy of olanzapine in first-episode psychotic disorders
1998-2001 Novartis Pharmaceuticals PI: Green	Clozapine vs. olanzapine in patients with schizophrenia and suicidality
2000-2002	A multicenter study of aripiprazole in the

Bristol-Myers Squibb — treatment of patients with acute schizophrenia
PI: Green

2000-2002 — A multicenter trial of iloperidone in patients with schizophrenia
Novartis Pharmaceuticals
PI: Green

2003-2005 — Atomoxetine plus olanzapine for cognitive dysfunction in schizophrenia
Eli Lilly & Co.
PI: Green

2004-2006 — Memantine in psychosis
Forest Laboratories
PI: Green

2008-2010 — Neurocognitive effect of sertindole versus quetiapine in patients with schizophrenia.
H. Lundbeck A/S
PI: Green

2008-2010 — A phase 2 study of LY2196044 compared with naltrexone and placebo in the treatment of alcohol dependence.
Eli Lilly and Co.
PI: Green

Teaching

1. Medical School Courses

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

2. Hospital Courses and Teaching Presentations

1982-	Psychopharmacology Lecture Series (Annual), Massachusetts Mental Health Center
1982-2002	Board Review Course (CME), Massachusetts Mental Health Center
1983-1993	Psychopharmacology Extramural Training Program (CME),

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

3. Invited Presentations

1972	How Basic Science Might Solve Social Problems in Substance Abuse, Society of Neurosciences, Houston, Texas
1986	New Research in Affective Disorders, Psychiatry Grand Rounds, University of Massachusetts
1989	Psychopharmacologic Probes in Psychotic Disorders, Psychiatry Grand Rounds, Dartmouth Medical School
1989	New Treatments for Psychosis, Grand Rounds, Fuller Memorial Hospital
1989	Psychopharmacology in the Substance Abusing Patient, Dual Diagnosis Conference, Fuller Memorial Hospital

1989	Treatment of Depression, Massachusetts Medical Society
1991	New Research in Psychosis, Medical Grand Rounds, Mt. Auburn Hospital, Harvard Medical School
1991	Psychopharmacologic Probes in Research on Psychosis, Psychiatry Grand Rounds, Beth Israel Hospital, Harvard Medical School
1991	New Anti-Psychotic Drugs, Massachusetts Psychiatry Society Scientific Meeting
1991	Seminar Leader, Biologic Basis of Schizophrenia, Psychosis Seminar, Beth Israel Hospital, Boston, MA
1991	Treatment-Resistant Psychosis, Psychiatry Grand Rounds, Boston University School of Medicine
1992	Biology of Psychosis, Psychosis Seminar, University of Massachusetts
1993	Seminar Leader, Interface of Psychopharmacology and Psychotherapy, Boston Psychoanalytic Institute
1993	Treatment-Resistant Psychosis, Brighton Marine Public Health Center, Brighton, MA
1993	Treatment-Resistant Psychosis, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1992	New Atypical Neuroleptic Drugs, Neurology Grand Rounds, West Roxbury VA Medical Center
1992	Endocrine Aspects of Psychiatric Disorders, Endocrine Grand Rounds, Brigham & Women's Hospital, Boston, MA
1992	Treatment-Resistant Depression, Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1994	Massachusetts Alliance for the Mentally Ill, Brookline Affiliate, Brookline, MA
1994	The New Pharmacology of Schizophrenia, Grand Rounds, Hartford Hospital, CT
1994	The Neurodevelopmental Basis of Schizophrenia, MA Department of Mental Health, Schizophrenia: State-of-the-Art Review Conference, Boston, MA
1994	The New Pharmacology of Schizophrenia, Dartmouth-Hitchcock Medical Center, Dartmouth Medical School, Grand Rounds, Lebanon, NH
1994	New Antipsychotic Medications, Alliance for the Mentally Ill of Cape Cod and the Islands, Hyannis, MA
1995	The New Pharmacology of Schizophrenia, Harvard-Longwood Behavioral Neurology Seminar, Brigham & Women's Hospital, Boston, MA
1995	Should the role of clozapine be expanded? American College of Neuropsychopharmacology, San Juan, PR
1995	New Antipsychotic Drugs, Psychiatry Grand Rounds, Stanford Medical Center
1996	Psychiatry Grand Rounds, St. Elizabeth's Hospital, Brighton, MA
1996	An expanded role for clozapine? New Clinical Drug Evaluation Unit Annual Meeting, FL
1996	Psychopharmacology Grand Rounds, McLean Hospital, Belmont, MA
1996	Response to Typical and Atypical Neuroleptics: Clinical Symptoms and Plasma HVA, Schizophrenia and Genetics Conference, Bilbao, Spain
1996	Psychiatry Grand Rounds, Dartmouth Medical School
1997	Psychiatry Grand Rounds, University of Massachusetts Medical Center
1997	Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center, Boston
1997	Psychopharmacology Rounds, Brigham and Women's Hospital, Boston
1997	Psychopharmacology Rounds, McLean Hospital, Belmont, MA
1997	Atypical Antipsychotics in Mood and Other Disorders, Stanford University School of Medicine

1998	Psychopharmacology Rounds, Cambridge Hospital, Cambridge, MA
1998	Psychiatry Grand Rounds, University of Rochester
1998	Novel antipsychotics in psychosis: changing expectations, Program Chair, Industry Symposium, APA annual meeting, Toronto
1998	Substance use disorder and schizophrenia: the role of antipsychotics, APA annual meeting, Toronto
1998	Psychiatry Grand Rounds, University of Vermont
1998	Early Intervention in Psychosis, Neurobiologic Basis. MA Department of Mental Health, Early Interventions in Psychosis Conference, Boston, MA
1999	Psychiatry Research Conference, University of Chicago
1999	Psychopharmacology of Schizophrenia, McLean Hospital
1999	Redefining Treatment-Resistant Schizophrenia, Program Chair and Lecturer, Industry Symposium, APA Annual Meeting, Washington, D.C.
1999	Effects of Antipsychotic-induced Prolactin Elevation, XI World Congress of Psychiatry, Hamburg, Germany
1999	Science Series, Tufts University School of Medicine, Department of Psychiatry
2000	Psychiatry Grand Rounds, University of Toronto.
2000	Psychiatry Grand Rounds, Downstate Medical Center, State University of New York
2000	Peter Curran Lecture, Mater Hospital Trust, Belfast, Northern Ireland
2000	Grand Rounds, Creedmore Psychiatric Center, Queens, New York.
2000	Chair, Gender, Schizophrenia and Antipsychotic Therapy. Second International Conference on Hormones, Brain and Neuropsychopharmacology. Rhodes, Greece
2000	Psychiatry Grand Rounds, Brown University School of Medicine.
2000	Lecturer, Arthur Noyes Schizophrenia Conference, Norristown State Hospital, PA
2000	Lecturer, Schizophrenia and Substance Abuse. Chile Psychiatric Association, La Serena, Chile (via videoconferencing).
2000	Massachusetts Psychiatric Society: Schizophrenia and comorbid substance use disorder.
2000	Treatments for Schizophrenia. Alliance for the Mentally Ill. Framingham, MA
2000	Psychiatry Grand Rounds, University of New Mexico, Albuquerque, NM
2000	Psychiatry Grand Rounds, Brockton VA Medical Center, Harvard Medical School
2001	Meeting the Challenge of Schizophrenia and Co-occurring Addictions, Program Chair. Industry Symposium, APA Annual Meeting
2001	Psychopharmacology of Comorbid Substance Use Disorders, Industry Symposium, APA Annual Meeting
2001	Substance Abuse and Schizophrenia, Satellite Symposium of 7th World Congress on Biological Psychiatry, Berlin, Germany
2001	Psychiatry Grand Rounds, Boston University Medical Center
2001	Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry
2001	Psychiatry Grand Rounds, University of Massachusetts Medical Center
2002	Psychiatry Grand Rounds, Wayne State School of Medicine, Detroit, MI
2002	Psychiatry Grand Rounds, University of Texas Southwestern, Dallas, Texas
2002	Psychopharmacology Conference, Silver Hill Hospital, New Canaan, Connecticut
2002	Research Seminar, Department of Psychiatry, Indiana University Mercer University
2003	Psychiatry Rounds, Harvard University Health Service, Cambridge, MA
2003	Schizophrenia and Substance Abuse, Thresholds Clinic, Chicago, Illinois
2003	Schizophrenia: Past, Present and Future, Central Vermont Medical Center
2003	Addiction Psychiatry Conference, SUNY Upstate Medical University, Syracuse, NY
2003	"Psychiatry and Neuroscience," Brattleboro Retreat Board of Directors, Grafton, VT

2004 Psychiatry Grand Rounds, Harvard Longwood Program in Psychiatry, Boston, MA

2004 Psychiatry Grand Rounds, University of Miami, Miami, Florida

2004 Psychiatry Grand Rounds, University of Pennsylvania, Philadelphia, PA

2004 Cannabis, Schizophrenia and Clozapine. Medications Development in Cannabis Dependence, NIDA, Rockville, MD

2004 Schizophrenia and Substance Abuse. Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France

2004 Can You Change the Course of Schizophrenia? Scandinavian College of Neuropsychopharmacology – Annual Meeting. Juan les Pins, France

2004 Psychiatry Grand Rounds, Yale Medical School, New Haven, CT

2004 Neuroscience Rounds, McLean Hospital, Harvard Medical School, Belmont, MA

2004 Neuropharmacology Seminar, Albany Medical College, Albany, NY

2004 Special Lecture: "What is Evidence?", McGill Dept of Psychiatry, Montreal, Canada

2004 Keynote Address: "Drugs and the Developing Brain: Adolescent Drug Use." Vermont Substance Abuse Conference, Fairlee, VT

2004 "Neurobiology of Addiction." Annual Scientific Convention, New Hampshire Medical Society, Bretton Woods, NH

2005 Keynote Address: "Early Intervention in Psychosis." NH Chapter of the Psychiatric Nursing Association, Stoweflake, VT

2005 "Substance Abuse and Psychosis." XII International Symposium about Current Issues and Controversies in Psychiatry, Barcelona, Spain

2005 Pharmacotherapy. Substance Abuse and Schizophrenia. Symposium, American Psychiatric Association Annual Meeting, Atlanta, GA

2005 "Drugs and the Developing Brain." Dartmouth Center for Addiction, Research and Education Symposium

2005 "Cannabis and Psychosis." Symposium at American Psychiatric Association Annual Meeting, Atlanta, GA

2005 "Novel Medications Development for Cannabis Dependence Targeting Brain Reward Circuitry." Symposium: Advancing Treatment for Marijuana Dependence. College on Problems of Drug Dependence Annual Meeting, Orlando, FL

2005 "Schizophrenia and Substance Abuse: A Reward Deficiency Syndrome?" Neurology Grand Rounds, Dartmouth Hitchcock Medical Center, Lebanon, NH

2005 "Schizophrenia and Co-occurring Substance Abuse: A Brain Reward Circuit Deficiency?" Dartmouth Symposium for the Life Science: Mechanisms of Brain Disorders. Dartmouth Hitchcock Medical Center, Lebanon, NH

2005 "Pharmacotherapy for Schizophrenia and Co-occurring Substance Use Disorders." International Meeting on Implications of Comorbidity for Etiology and Treatment of Neuropsychiatric Disorders. Mazagón, Spain

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

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

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

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

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

2006	"Drugs, Alcohol and Teens." Turner Lecture Series. Sponsored by West Central Behavioral Health, Department of Psychiatry, Dartmouth Medical School, National Alliance for the Mentally Ill.
2006	"The Clinician's Dilemma: When to Use Two Antipsychotics?" I³dln Teleconference, Atlanta, GA.
2006	"Substance Abuse and the Onset, Severity and Treatment of Schizophrenia." International Society of Addiction Medicine (VIII ISAM Meeting), Oporto, Portugal.
2006	"Schizophrenia and Substance Abuse: Is it all about Reward?" New Frontiers in Psychiatry, Stowe, VT.
2006	Vermont State Substance Abuse Conference, Lake Morey, VT.
2006	"Treatment of Comorbid Cannabis Use and Schizophrenia." American Academy of Child and Adolescent Psychiatry Annual Meeting, San Diego, CA.
2007	Joseph J. Schildkraut Memorial Lecture, University of Massachusetts
2007	Psychiatry Grand Rounds, Vanderbilt University, Nashville, TN.
2008	"Schizophrenia and Substance Abuse: Is it all about rewards?" Psychiatry Grand Rounds, Maine Medical Center, Portland, ME.
2008	"Deconstructing Clozapine: Toward New Medications for Alcoholism." NIAAA, Washington, DC.
2008	"Schizophrenia and Substance Abuse: Is it all about rewards?" Psychiatry Grand Rounds, Tufts Medical Center, Boston, MA.
2008	"Lifting the Veil on Mental Illness: Science in Psychiatry." Dartmouth Community Medical School
2008	"Targeting Reward Circuitry: Medication Development for Schizophrenia and Substance Abuse." 1st Annual Chairs Summit, Hilton Head Island, SC. June 27-29.
2009	"Schizophrenia and Substance Abuse: Approaching Pharmacotherapy." Plenary Session, CINP Thematic Conference, Edinburgh, UK. April 25-27.
2009	"A Translational Perspective on Clozapine: Clinical Utility." CINP Thematic Conference, Edinburgh, UK. April 25-27.
2009	"Update on the Pharmacologic Treatment of Schizophrenia." American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.
2009	"Treatment of Schizophrenia and Co-Occurring Alcoholism." American Psychiatric Association Annual Meeting, San Francisco, CA. May 16-21.
2009	"Cannabis and Psychosis." Australian National Cannabis Conference, Sydney, Australia. September 7-8.
2009	"Deconstructing Clozapine: Toward Medication for Alcoholism in Schizophrenia." Psychiatry Grand Rounds, McMaster University, Hamilton, ON, Canada. September 16.
2009	"Cannabis and Schizophrenia" October 27-November 1. American Association of Child and Adolescent Psychiatry Annual Meeting. Honolulu, HI.
2010	"Concurrent Treatment of Cannabis Dependence in Patients with Schizophrenia." American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.
2010	"Non-Psychotic Issues of Schizophrenic Patients: Schizophrenia and Substance Abuse." American Psychiatric Association Annual Meeting, New Orleans, LA. May 22-26.
2010	"Treatment of Schizophrenia and Co-Occurring Alcoholism" Research Society on Alcoholism Annual Meeting, San Antonio, TX. June 26-30.
2010	"Essential Psychopharmacology, 2010: Practice and Update" Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 2-6.
2011	"Essential Psychopharmacology, 2011: Practice and Update" Harvard Medical School Summer Seminars, North Falmouth, MA (Cape Cod). August 1-5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Formally Supervised Trainees (and current position)

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

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

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

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

1994 – 1998 Rahim Shafa, M.D. (Post-doctoral Fellow)

	Director, Novel Clinical Psychopharmacology Care, Natick, MA Staff Psychiatrist, Metrowest & Greater Boston CNS Research Center
1995 – 1997	Carla Canuso, M.D. (Post-doctoral Fellow) Senior Director of Neuroscience External Innovation at Johnson & Johnson
1997 – 1999	James Kelleher, M.D. (Post-doctoral Fellow) Associate Professor, Clinical Psychiatry and Behavioral Sciences, New York Medical College
1998 – 1999	Carmela Perez, Ph.D. (Post-doctoral Fellow) Private Practice Psychoanalyst, New York, NY Assistant Professor of Psychiatry, St. Vincent's Hospital Assistant Professor of Psychiatry, New York Medical College
1998 – 2000	Rael Strous, M.D. (Post-doctoral Fellow) Professor of Psychiatry, Sackler School of Medicine, Tel Aviv University. Senior Psychiatrist, Be'er Ya'aqov Mental Health Center, Tel Aviv.
1998 – 2001	Jaskaran Singh, M.D. (Post-doctoral Fellow) Senior Director, Clinical Research, Neuroscience at Janssen, Johnson & Johnson Pharmaceutical Research and Development, San Diego, CA
1999 – 2001	Michael Rodriguez, Ph.D. (Post-doctoral Fellow) Assistant Professor, Department of Psychology, Harvard University
2000 – 2001	Amani Michael, M.D. (Post-doctoral Fellow) Psychiatrist, Integrated Behavioral Associates, Weymouth, MA
2000 – 2001	Wilson Woo, M.D., Ph.D. (Post-doctoral Fellow) Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA. Director, Laboratory of Cellular Neuropathology, McLean Hospital, Boston, MA Medical Director, Harvard Brain Tissue Resource Center, Beth Israel Deaconess Medical Center, Boston, MA.
2001 – 2003	David Chau, Ph.D. (Post-doctoral Fellow) Founder and President of Amazing Grace Pharmaceuticals
2002 – 2006	Vivianne Tawfik, M.D., Ph.D. (Pre-doctoral Student) Instructor, Anesthesiology, Perioperative and Pain Medicine Stanford School of Medicine, Stanford, CA.
2005 – 2006	Timothy Laumann (Dartmouth Undergraduate) M.D. Ph.D. student, Washington University, St. Louis
2007 – 2010	Matthew Garlinghouse, Ph.D. (Post-doctoral Fellow) Senior Neuropsychologist at Henry Ford Health Systems, Detroit, MI.
2007 – 2010	Michael Henderson, J.D. (Pre-doctoral Student) Associate University Counsel, Temple University, Philadelphia, PA.
2009 – 2010	Victoria Stockman (Dartmouth Undergraduate) PhD Student, Department of Systems Biology, Columbia University Graduate School of Arts and Sciences, New York, NY.
2009 – 2011	Danielle Gulick, Ph. D. (Post-doctoral Fellow) Assistant Professor, Morsani College of Medicine, University of South Florida
2009 – 2011	Natalie Colaneri (Dartmouth Undergraduate) Visiting Researcher, Oxford Uehiro Centre for Practical Ethics, University of Oxford, England.
2010 – 2011	Eric Arehart, M.D. Ph.D. (Post-doctoral Fellow) Resident, Neurology, Duke Children's Hospital & Health Center, Durham, NC.
2010 – 2012	Yip Wong, B.S. (Pre-doctoral Fellow – Program in Experimental Molecular

Medicine)

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

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

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

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

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

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

2013 – Hersh Trivedi
Dartmouth Undergraduate Student

2013 – Michael Sun
Dartmouth Undergraduate Student

2013 – Mia Harrow-Mortelliti
Dartmouth Undergraduate Student

2014 – Nicholas Deveau
Dartmouth Undergraduate Student

2014 – 2014 David Mallick
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2014 – Jared Boyce
Dartmouth Undergraduate Student

2015 – Amanda Simon
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2015 – Megan Cheng
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2015 – 2015 Carey Allmendinger
Dartmouth Graduate Rotation Student

2015 – Rebecca Zegans
Wesleyan Undergraduate Student

2015 – Robert Tokhunts
Dartmouth Medical Student

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Articles

1. Snyder SH, Green A, Hendley ED, Gfeller E. Noradrenaline: kinetics of accumulation into slice from different regions of rat brain. Nature. 1968; 218: 174-176.

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243. Renshaw PF, Yurgelun-Todd DA, Wei H, Charles HC, Cohen BM, Tohen MF, Sharma T, Zipursky R, Kahn R, Gur R, Green AI, McEvoy J, Perkins D, Hamer RM, Nemeroff C, Rothchild A, Kuldau J, Strakowski S, Tollefson G, Lieberman J, and the HGDH Research Group. Olanzapine induced reductions in frontal lobe lactate levels correlate with treatment response in first episode psychosis. American College of Neuropsychopharmacology Annual Meeting Abstracts, 2003, 370.

244. Green AI, Keung WM, Chau DT, Dawson R, Mesholam RI, Schildkraut JJ. Clozapine Limits Alcohol Drinking in Hamsters: Implications For Treatment Of Schizophrenia. Schizophrenia Research, 2003; 60(1):312.

245. Lieberman J, Charles HC, Sharma T, Zipursky R, Kahn R, Gur R, Tohen M, Green AI, McEvoy J, Perkins D, Hamer RM, Nemeroff C, Rothschild A, Kuldau J, Strakowski S, Tollefson GD. Antipsychotic Treatment Effects On Progression Of Brain Pathomorphology In First Episode Schizophrenia. Schizophrenia Research, 2003; 60(1):293.

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248. McEvoy J, Lieberman JA, Perkins D, Hamer RM, Sharma T, Zipursky R, Kahn R, Gur R, Centorrino F, Glick I, Green AI, Nemeroff C, Rothschild A, Strakowski S, Tohen M, Tollefson, GD. Long-Term Efficacy And Safety Of Atypical And Conventional Antipsychotic Drugs In First Episode Schizophrenia. Biological Psychiatry, 2003;53(85):65S.

249. Renshaw PF, Yurgelun-Todd DA, Wei H, Charles HC, Tohen M, Sharma T, Zipursky RB, Kahn R, Gur RE, Green AI, McEvoy JP, Perkins DO, Hamer RM, Nemeroff CB, Rothschild AJ, Kuldau JM, Strakowski SM, Tollefson GD, Lieberman JA. Olanzapine Induced Reductions In Frontal Lobe Lactate Levels Correlate With Treatment Response in First Episode Psychosis. Biological Psychiatry, 2003; 53(8S):67S.

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251. Perkins DO, Lieberman JA, Gu H, Tohen M, McEvoy JP, Green AI, Zipursky RB, Strakowski SM, Sharma T, Kahn R, Gur RE, Tollefson GD. Predictors Of Antipsychotic Treatment Response In Patients With First Episode Schizophrenia, Schizoaffective, and Schizophreniform Disorders. Biological Psychiatry, 2003; 53(8S):182S-183S.

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254. Green AI. Schizophrenia and substance abuse. Role of antipsychotics. Nordic Journal of Psychiatry, 2004; 58(2): 89.

255. Zipursky RB, Gu H, Charles C, Sharma T, Green AI, Gur RE, Kahn RS, Perkins D, Keefe R, Hamer RM, Tollefson GD, Tohen M, Lieberman JA. Clinical Correlates of MRI Brain Volumes in First Episode Psychosis, Schizophrenia Bulletin, 2005; 31(2): 408

256. Dunayevich E, Zhao F, Ascher-Svanum A, Mitchell CP, Phillips GA, Dellva MA, Green A. Longer time to all-cause antipsychotic discontinuation is associated with better schizophrenia treatment outcomes, Biol Psychiatry, 2005; 57:107S

257. Chau DT, Green AI. Aripiprazole Decreases Alcohol Drinking in Syrian Golden Hamsters. Neuropsychopharmacology, 2005; 30 (Suppl 1): S144-S145.

258. Green AI. Substance Abuse and Schizophrenia. Pharmacological Approaches. 24th CINP Congress. International Journal of Neuropsychopharmacology, 2006; 9(Suppl 1): S43.

259. Green AI, Brunette M, Noordsy D, Roth R. Treatment of comorbid cannabis use and schizophrenia. AACAP Annual Meeting Scientific Proceedings, 2006.

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

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

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

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

264. Whitfield-Gabrieli S, Thermenos HW, Milanovic S, Tsuang MT, Faraone SV, McCarley RW, Shenton ME, Green AI, LaViolette P, Wojcik J, Gabrieli JDE. Hyperactivity and Hyperconnectivity of the Default Network in Schizophrenia and in First Degree Relatives of Persons with Schizophrenia. Biological Psychiatry, 2008: 63(7 supplement 1): 272S.

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

266. Green AI, Brunette MF, Dawson R, Narasimhan M, Wallace A, Herz M, Sommi R, Buckley P, R-LAST Study Team. Oral vs. Long-acting Injectable Risperidone in Schizophrenia and Co-Occurring

Alcohol Use Disorder. American College of Neuropsychopharmacology Annual Meeting Abstracts. Neuropsychopharmacology, 34, 2009.

267. Narasimhan M, Brunette MF, Dawson R, O'Keefe CD, Weeks MH, Buckley PF, Green AI. Long-acting Risperidone for Schizophrenia and Co-Occurring alcohol Use Disorder. Abstracts for the 12th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2009: 35(suppl 1): 343.

268. Noordsy DL, Marshall JF, Smith JN, Green AI. Clozapine vs. Risperidone for People with First Episode Schizophrenia and Co-Occurring Cannabis Use Disorder. Abstracts for the 12th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2009: 35(suppl 1): 366.

269. Brunette M, Green AI, Buckley PF, O'Keefe C, Dawson R. Quetiapine for the Treatment of Patients with Schizophrenia and Alcohol Use Disorders. Abstracts for the 12th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2009: 35(suppl 1): 371.

270. Gulick D, Chau DT, Green AI. Clozapine decreases alcohol consumption but not sucrose consumption in Syrian Golden hamsters. Society for Neuroscience Annual Meeting 2009 Abstracts.

271. Gulick D, Chau D, Ahmed J, Wang T, Xie H, Dawson R, Green A. Raclopride Lessens the Ability of Clozapine to Suppress Alcohol Drinking in Syrian Golden Hamsters. American College of Neuropsychopharmacology Annual Meeting Abstracts. Neuropsychopharmacology, 35, 2010: S285.

272. Gulick D, Green AI. Role of caloric content and reward value in the consumption of alcohol by the Syrian golden hamster. Program No. 66.4. 2010 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2010. Online.

273. Noordsy D, Smith JN, Green AI. Clozapine vs. Risperidone for People with First Episode Schizophrenia and Co-Occurring Cannabis Use Disorder. Second Biennial Schizophrenia International Research Society Conference. Schizophrenia Research, 2010, 117(2): 165-166.

274. Liebman HM, Pietersen CY, Thermenos H, Seidman LJ, Green AI, Woo TUW. The addition of tiagabine to antipsychotic medication in the treatment of recent-onset schizophrenia by modification of developmental pruning of prefrontal circuitry. Program No. 880.26. 2010 Neuroscience Meeting Planner. San Diego, CA: Society for Neuroscience, 2010. Online.

275. Abdel-Fadeel NAM, McCarley R, Mesholam-Gately R, Wojcik J, Green A, Goldstein JM, Seidman LJ. Gender Differences in Clinical Presentation of First Episode Psychosis: Relationship to Premorbid Adjustment. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 275.

276. Green A, Chau DT, Gulick D, Ahmed J, Epstein K, Dawson R. Deconstructing clozapine: Toward medication development for alcoholism in schizophrenia. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 288.

277. Brunette MF, Dawson R, O'Keefe CD, Narasimhan M, Noordsy D, Wojcik J, Green AI. Clozapine vs. other antipsychotics for schizophrenia and co-occurring cannabis use disorder. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 297.

278. Shaskan NK, Thermenos HW, Seidman LJ, Green A, Woo TUW. The addition of tiagabine to antipsychotic medication in the treatment of recent-onset schizophrenia by modification of developmental reorganization of prefrontal circuitry. Abstracts for the 13th International Congress on Schizophrenia Research. Schizophrenia Bulletin, 2011: 37(suppl 1): 320.

Curriculum Vitae

William Roger Keller, M.D.
Assistant Professor, Department of Psychiatry, Geisel School of Medicine at Dartmouth

Date

January 12, 2016

Education

2002	B.A., Mathematics, University of Maryland Baltimore County (Cum Laude)
2006	M.D., University of Texas Southwestern Medical School

Post Graduate Education and Training

2006 – 2011	Residency Research Track, Psychiatry, University of Maryland / Sheppard Pratt (Mentor Robert Buchanan, MD)
2011 – 2013	Fellowship, NIMH-Funded (T32) Multidisciplinary Schizophrenia Research Fellowship, Maryland Psychiatric Research Center, University of Maryland School of Medicine (Mentor Robert Buchanan, MD)

Certifications

2011	Diplomat, American Board of Psychiatry and Neurology (ABPN)
2011	DEA-Recognized Waiver for Prescribing Narcotics for Maintenance or Detoxification (allows prescription of buprenorphine in an office based setting)

Medical Licensures

2015	New Hampshire, Active
2008	Maryland, Active

Military Service

2012 – present	Direct Commissioned Officer, Medical Corps, United States Army (Reserve Component) Rank: Major (O4) 327th Combat Stress Control, Fort Dix, New Jersey

Employment

2016 – present	Assistant Professor of Psychiatry, Geisel School of Medicine at Dartmouth
2013 – 2015	Assistant Professor of Psychiatry, University of Maryland School of Medicine
2013 – 2015	Psychiatrist Baltimore VA Medical Center, Without Compensation Appointment
2010 – 2013	Staff Psychiatrist, Sheppard Pratt Hospital, Towson, Maryland (part-time)
2010 – 2013	Psychiatrist on Duty, Baltimore VA Medical Center, Baltimore, Maryland (per diem)

Professional Society Memberships

2003 - present	American Medical Association
2010 - present	American Psychiatric Association

2010 - 2015 Maryland Psychiatric Society
2010 - 2015 Maryland State Medical Society

Honors and Awards

1998 - 2002 Maryland Distinguished Scholar Award, Merit Scholarship
1998 - 2002 President's Fellow Award at University of Maryland Baltimore County, Merit Scholarship
2001 Golden Key National Honor Society
2002 Phi Beta Kappa
2004 Outstanding Presentation at 42nd Medical Student Research Forum
2006 Excellence on the PRITE (Psychiatry Resident in Training Exam)
2007 Excellence on the PRITE (Psychiatry Resident in Training Exam)
2009 Excellence on the PRITE (Psychiatry Resident in Training Exam)
2009 Workshop Fellow American Society of Clinical Psychopharmacology Workshop on Clinical Trials
2011 Taylor Award for Best Resident Research Paper, University of Maryland School of Medicine, Department of Psychiatry
2011 American Psychiatric Institute for Research and Education (APIRE)/Clinical Trials Research Fellowship Award, American Psychiatric Association (stipend $45,000)
2012 The International Society for CNS Clinical Trials and Methodology New Investigator Award
2012 Seventeenth Annual Research Colloquium Award for Junior Investigators sponsored by American Psychiatric Association APA Workgroup on Research Training

Clinical Activities and Expertise

Board certified psychiatrist with clinical and research focus in the area of chronic and severe mental illness, schizophrenia, and schizoaffective disorder.

Administrative Service

Institutional Service

2007 – 2009 University of Maryland Medical Center Hospital Ethics Committee
2007 Donaldson Brown Psychiatry Resident Retreat Committee

National Service

ad hoc Reviewer Schizophrenia Bullctin
Clinical Schizophrenia and Related Psychoses
BMJ Case Reports

Teaching Service

Supervision/Mentoring

2011 -2012 Supervisor, University of Maryland School of Medicine, Psychiatry Resident Research Elective; Supervision during research elective with ongoing project evaluating emotions in schizophrenia, recruited participants and administered behavioral tasks
Carol Vidal; 6 months, Mentor 2011 – 2012, 4 contact hours per week

2011 – 2012 Supervisor, University of Maryland School of Medicine, MPRC volunteer intern
Supervision during ongoing research project evaluating emotions in schizophrenia, recruited participants and administered behavioral tasks
Yaakov Shugarman; 6 months, Mentor 2011 – 2012, 4 contact hours per week
[Argosy University; Doctor of Psychology; Matriculated Fall 2012]

2012 – present Clinical Skills Verification Examiner, American Association of Directors of Psychiatric Residency Training (AADPRT) version of assessment

Medical Student Teaching

2006 - 2008 Clinical supervision of medical students during their psychiatry clerkship 1 to 2, 3rd year medical students 8 hours/day, 11 months/year

2009 - 2010 Moderator Spring Grove Hospital Clinical Case Conference for Junior Psychiatric Residents and Medical Students – 1 resident, 15 3rd year medical students, 4 contact hours/year

2009 – 2010 Moderator Medical Student Teaching Introduction to Clinical Medicine Psychiatric Interviewing Skills, 8 2nd year medical students, 3 contact hours/year

2014 – 2015 Preceptor 3rd year Medical Student Clerkship for Outpatient Clinic, 24 contact hours/year

2015 – 2015 Moderator Medical Student Teaching Introduction to Clinical Medicine Psychiatric Interviewing Skills, 3 2nd year medical students, 3 contact hours/year

Psychiatry Resident Teaching

2010 - 2014 Lecturer for Senior Psychiatric Residents Advanced Psychopharmacology Class; "Atypical Antipsychotics" and "Treatment Resistant Depression"; – 10 residents, 2 contact hours/year

2011 - 2015 Lecturer for Junior Psychiatric Residents Schizophrenia Course; "Course and Prognosis of Schizophrenia" – 10 residents, 1 contact hours/year

2013 –2015 Clinical supervisor of psychiatry resident outpatient rotation, 3rd year psychiatry resident, 12 months/year

Grants

Inactive

09/01/2011 – 08/31/2012 PI: Keller, under supervision of Bernard Fischer MD
Infection and Inflammation in Schizophrenia
VISN 5 MIRECC Pilot Grant
Total Direct Costs: $24,667

Publications

Peer-reviewed journal articles

1. Buchanan RW, Kreyenbuhl J, Kelly DL, Noel JM, Boggs DL, Fischer BA, Himelhoch S, Fang B, Peterson E, Aquino PR, **Keller W**. The 2009 schizophrenia PORT psychopharmacological treatment recommendations and summary statements. Schizophrenia Bulletin. 2010 Jan;36(1):71-93.

2. **Keller WR**, Fischer BA, Carpenter WT Jr. Revisiting the diagnosis of schizophrenia: Where have we been and where are we going? CNS Neuroscience & Therapeutics. 2011 Apr;17(2):83-8.

3. Fischer BA, **Keller WR**, Arango C, Pearlson GD, McMahon RP, Meyer WA, Francis A, Kirkpatrick B, Carpenter WT, Buchanan RW. Cortical structural abnormalities in deficit versus nondeficit schizophrenia. Schizophrenia Research. 2012 Apr;136(1-3):51-4.

4. Strauss, G.P., Hong, L.E., **Keller, W.R.**, Buchanan, R.W., Gold, J.M., Fischer, B.A., McMahon, R.P., Catalano, L.T., Culbreth, A.J., Carpenter, W.T., Kirkpatrick, B. Factor Structure of the Brief Negative Symptom Scale. Schizophrenia Research 2012;142:96-8.

5. Strauss, G.P., **Keller, W.R.**, Buchanan, R.W., Gold, J.M., Fischer, B.A., McMahon, R.P., Catalano, L.T., Culbreth, A.J., Carpenter, W.T., Kirkpatrick, B. Next-Generation Negative Symptom Assessment

for Clinical Trials: Validation of the Brief Negative Symptom Scale. Schizophrenia Research. 2012;142:88-92.

6. **Keller WR**, Kum LM, Wehring HJ, Koola MM, Buchanan RW, Kelly DL. A review of anti-inflammatory agents for symptoms of schizophrenia. Journal of Psychopharmacology. 2013;27:337-42.

7. Strauss GP, Horan WP, Kirkpatrick B, Fischer BA, **Keller WR**, Miski P, Buchanan RW, Green MF, Carpenter WT Jr. Deconstructing negative symptoms of schizophrenia: Avolition-apathy and diminished expression clusters predict clinical presentation and functional outcome. J Psychiatr Res 2013;47:783-90.

8. Kelly DL, Wehring HJ, Earl AK, Sullivan KM, Dickerson FB, Feldman S, McMahon RP, Buchanan RW, Warfel D, **Keller WR**, Fischer BA, Shim JC. Treating symptomatic hyperprolactinemia in women with schizophrenia: presentation of the ongoing DAAMSEL clinical trial (Dopamine partial Agonist, Aripiprazole, for the Management of Symptomatic ELevated prolactin). BMC Psychiatry. 2013 Aug 22;13:214.

9. **Keller WR**, Fischer BA, McMahon R, Meyer W, Blake M, Buchanan RW. Community adherence to schizophrenia treatment and safety monitoring guidelines. J Nerv Ment Dis. 2014 Jan;202(1):6-12.

10. **Keller WR**, Vidal C, Park ES, Strauss GP, Fischer BA. The risk of diabetes in deficit schizophrenia. Clin Schizophr Relat Psychoses. 2014 Jan;7(4):235-7

11. Buchanan RW, Weiner E, Kelly DL, Gold JM, **Keller WR**, Waltz JA, McMahon RP, Gorelick DA. Rasagiline in the Treatment of the Persistent Negative Symptoms of Schizophrenia. Schizophr Bull. 2014 Nov 2

12. Strauss GP, **Keller WR**, Koenig JI, Gold JM, Ossenfort KL, Buchanan RW. Plasma oxytocin levels predict olfactory identification and negative symptoms in individuals with schizophrenia. Schizophr Res. 2015 Jan 9

13. Strauss GP, **Keller WR**, Koenig JI, Sullivan SK, Gold JM, Buchanan RW. Endogenous oxytocin levels are associated with the perception of emotion in dynamic body expressions in schizophrenia. Schizophr Res. 2015 Jan 22

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14. Warren, K.R., **Keller, W.** & Kelly, D.L. (2015). Brief Psychotic Disorder, *British Medical Journal*, online monograph (update): https://online.epocrates.com/u/29111118/Brief+psychotic+disorder.

15. Kelly DL, Sullivan KM, McEvoy JP, McMahon RP, Wehring HJ, Gold JM, Liu F, Warfel D, Vyas G, Richardson CM, Fischer BA, **Keller WR**, Koola MM, Feldman SM, Russ JC, Keefe RS, Osing J, Hubzin L, August S, Walker TM, Buchanan RW. Adjunctive Minocycline in Clozapine-Treated Schizophrenia Patients With Persistent Symptoms. J Clin Psychopharmacol. 2015 Aug;35(4):374-81.

Abstracts

1. **Keller WR**, Fischer BA, Meyer W, Blake M, McMahon R, Buchanan RW. Second generation antipsychotics in community treatment for schizophrenia. Schizophrenia Bulletin. 2011 Mar:37(suppl 1):98

2. Kreyenbuhl J, Buchanan R, Kelly D, Noel J, Boggs D, Fischer B, Himelhoch S, Fang B, Peterson E, Aquino P, **Keller W**. The 2009 schizophrenia patient outcomes research team (PORT)

psychopharmacological treatment recommendations. International Clinical Psychopharmacology. 26():e54-e55, September 2011.

3. Fischer BA, Rowland LM, **Keller WR**, Holcomb HH, Buchanan RW. Acamprosate acts as a partial agonist of the NMDA receptor: Evidence from a spectroscopy study in schizophrenia. ACNP 2011

4. Fischer BA, **Keller WR**, Vidal C, Park ES, Strauss GP. The risk of diabetes in deficit schizophrenia. Schiz Bulletin 2013;39 (suppl 1) 30-1.

Brief Communications

1. **Keller W**, Buchanan RW. Oxytocin and DMXB as Possible Treatments in Schizophrenia. VA Capital Health Care Network (VISN5), Mental Illness Research, Education, and Clinical Center (MIRECC). MIRECC Matters. 2009 Feb Volume 10 Issue 1

2. **Keller WR**. Review of The Recognition and Management of Early Psychosis edited by Henry J. Jackson and Patrick C. McGorry. New York: Cambridge University Press, 2009. Journal of Nervous and Mental Disease. 198(9):696-697, September 2010.

3. **Keller WR**, Vidal C, Park ES, Strauss GP, Fischer BA. The risk of diabetes in deficit schizophrenia [Letter to the Editor]. Clinical Schizophrenia and Related Psychoses. 2013 Mar 14:1-7.

4. **Keller WR**, Fischer BA, McMahon R, Meyer W, Buchanan RW. Open-Label Salsalate for the Treatment of Pre-diabetes in People with Schizophrenia [Letter to the Editor]. Schizophrenia Research 2013 Jul;147(2-3):408-9

Major Invited Speeches

Local

1. "Leukoariosis was quantitatively compared in Alzheimer's patients and normal controls using MR imaging of the brain."; 42nd Medical Student Research Forum University of Texas Southwestern Medical School, Dallas, TX. 2004

National

1. "Second generation antipsychotics in community treatment for schizophrenia."; 13th International Congress on Schizophrenia Research, Colorado Springs, CO. 2011

Proffered Communications

1. Fischer BA, **Keller WR**, Arango C, Pearlson G, McMahon RP, Meyer W, Francis A, Kirkpatrick B, Carpenter WT, Buchanan RW. Cortical structural abnormalities in deficit versus nondeficit schizophrenia. (Poster presented at the annual meeting of the American College of Neuropsychopharmacology, Miami Beach, FL.) December 2010

2. **Keller WR**, Fischer BA, Meyer W, Blake M, McMahon R, Buchanan RW. Second generation antipsychotics in community treatment for schizophrenia. (Poster presented at University of Maryland School of Medicine, Department of Psychiatry Research Day, Baltimore, MD.) May 2011

3. Fischer BA, Rowland LM, **Keller WR**, Holcomb HH, Buchanan RW. Acamprosate acts as a partial agonist of the NMDA receptor: Evidence from a spectroscopy study in schizophrenia. (Poster presented at the annual meeting of the American College of Neuropsychopharmacology, December 2011,Waikoloa Beach, HI.) December 2011

4. **Keller WR**, McMahon R, Buchanan RW. Salsalate for the Treatment of Pre-diabetes in People with Schizophrenia. (Poster presented at the International Society for CNS Trial and Clinical Methodology, Washington DC) February 2012

5. Catalano, L.T., **Keller, W.R.**, Lee, B.G., Martins, D.O., Adams, J.L, Shugarman, Y.Y., Llerena, K., Gold, J.M., Buchanan, R.W., Strauss, G.P. The nature of emotional experience abnormalities in schizophrenia: Is it affective ambivalence or negative emotionality? (Poster presented at the Society for Research in Psychopathology, Ann Arbor, MI.) October 2012

6. Strauss, G.P., **Keller, W.R.**, Koenig, J.I., Catalano, L.T., Adams, J.L, Gold, J.M., Buchanan, R.W. Plasma Oxytocin Levels Predict Olfactory Identification and Hedonic Judgments in Individuals with Schizophrenia. (Poster presented at the Society for Research in Psychopathology, Ann Arbor, MI.) October 2012

7. Gregory P. Strauss, **William R. Keller**, James M. Gold, Robert W. Buchanan Associations between peripheral oxytocin levels and impaired social cognition in schizophrenia (Poster presented at the Schizophrenia International Research Conference, Florence, Italy.) April 2014

8. Ariel B. Katz, **William R. Keller**, James M. Gold, Robert W. Buchanan, Gregory P. Strauss Plasma Oxytocin Levels Predict Social Cue Recognition in Schizophrenia (Poster presented Society for Research in Psychopathology, Evanston, IL.) September 2014

9. Kayla M. Whearty, **William R. Keller**, James M. Gold, Robert W. Buchanan, Gregory P. Strauss Emotional Memory Impairment in Schizophrenia: An Encoding or Retrieval Deficit? (Poster presented Society for Research in Psychopathology, Evanston, IL.) September 2014

10. Katherine H. Frost, **William R. Keller**, Robert W. Buchanan, James M. Gold, James I. Koenig, Kathryn Ossenfort, Ariel B. Katz, Gregory P. Strauss Plasma Oxytocin Levels are Associated with Impaired Social Cognition and Neurocognition in Schizophrenia (Poster presented Society for Research in Psychopathology, Fajardo, PR.) November 2014

11. Britta Hahn, Alexander N. Harvey, Bernard A. Fischer, **William R. Keller**, Thomas J. Ross, Elliot A. Stein Nicotinic Modulation of the Default Network of Resting Brain Function in Non-Smokers (Poster presented at American College of Neuropsychopharmacology, Phoenix, AZ.) December 2014

David W. Lynde, MSW, LICSW
Mental Health Services Consultant & Trainer

Education

- Boston University, Masters in Social Work, 1992
- University of New Hampshire, B.A. in Social Work, 1982

Employment

David W Lynde Independent Consultant and Trainer Implementing Evidence Based Mental Health Practices, 2004 - Present

- Deputy Project Director for Dissemination for the National Registry for Evidence-based Practices and Programs (NREPP) for the Substance Abuse and Mental Health Services Administration (SAMHSA) (Developmental Services Group, Inc.)
- Consultant to Arizona Department of Health Services vis-à-vis National Association of State Mental Health Program Directors regarding implementation of four EBPs
- Consultant to United States Department of Justice regarding Supported Employment implementation for State of Georgia Olmstead Settlement Agreement
- Consultant to Marc Gould Associates regarding the development and implementation of the Pathways to Careers employment model for people with mental illness
- Co-Director, Atlas Research & Easter Seals National Training Program for Veteran Administration Homeless Veteran Supported Employment Program
- Consultant and Trainer for Department of Veterans Affairs regarding national implementation of Supported Employment in Compensated Work Therapy program
- Developer, Trainer and Consultant regarding NIMH RAISE project for Supported Employment and Supported Education for national first episode psychosis project
- Evidence Based Practices implementation consultation and technical assistance to multiple state, county, municipal and national mental health systems regarding implementation of Evidence Based Mental Health Practices

Dartmouth Psychiatric Research Center, 2000-2013

- Co-Director, Dartmouth Evidence Based Practices (EBP) Center for Implementing Evidence-Based Mental Health Practices
- Consultant and Trainer regarding Organizational Change and Implementation of Evidence-Based Practices for State, County and Municipal Mental Health Systems
- Developer, Technical Assistant and Consultant regarding five Evidence Based Practices "toolkits" and implementation process for National Implementing Evidence Based Practices Project from SAMHSA
- Co-developer of the State Health Authority Yardstick (SHAY) to measure and guide State and System level implementation actions for evidence-based mental health services.
- National Core Staff, Johnson & Johnson – Dartmouth Community Mental Health Program for multi-state implementation of Supported Employment Services

- Director of Consultation and Training services regarding implementation of EBPs for NH Bureau of Behavioral Health
- 2005-2008 Information technology workgroup leader and leadership committee member, Governor's Commission on the transformation of services for mental illness in New Hampshire
- Co-Chair and Quality Workgroup Leader for NH Governor's Commission on the transformation of mental health services

University of New Hampshire, Durham, NH
- Adjunct Faculty, Social Work Department, 1994-2005
- UNH Social Work Department Advisory Board, 1992-2010

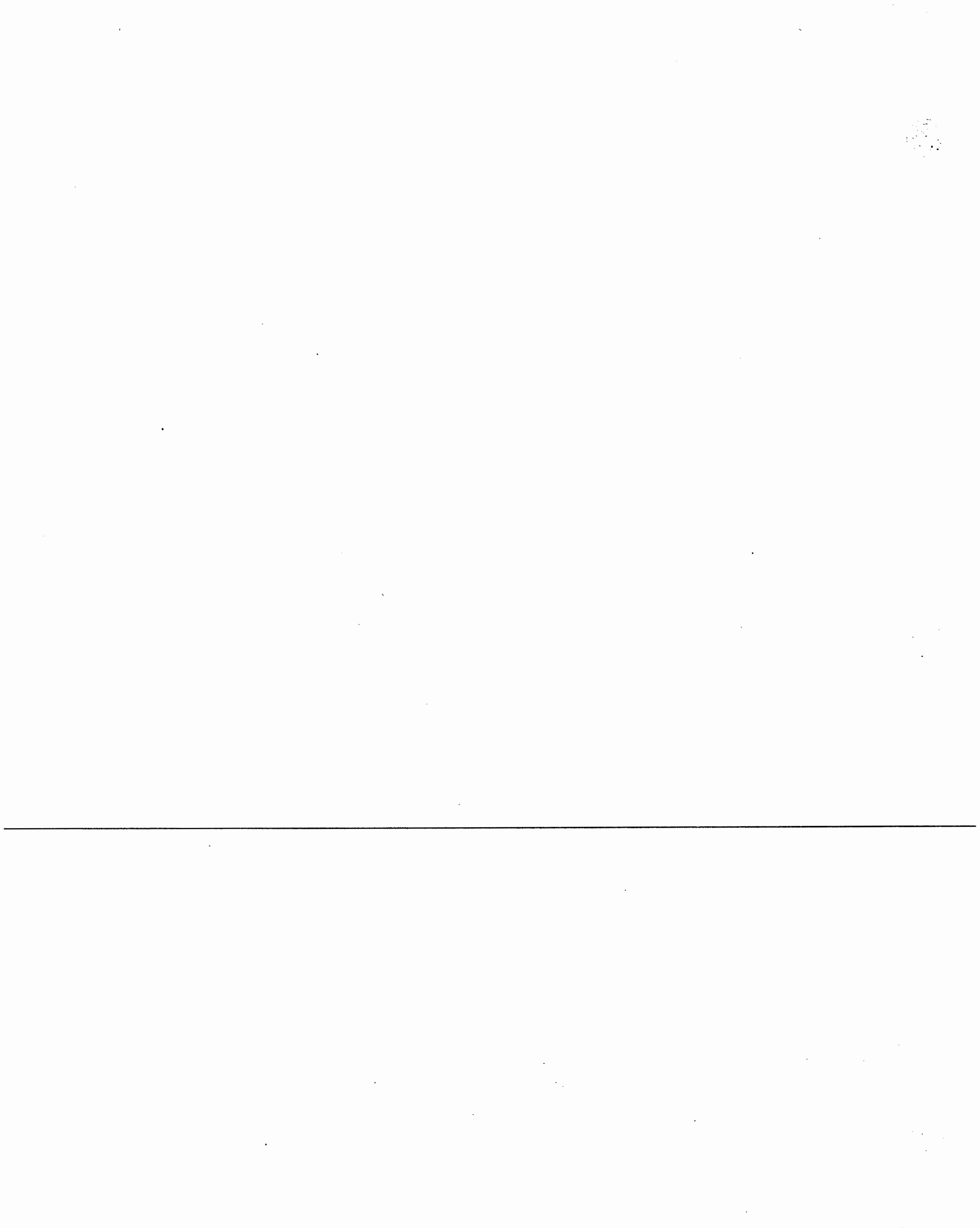
Boston University School of Social Work
  - Adjunct Faculty, Graduate Social Work Program 2004-2005

Center for Life Management, Community Mental Health Center, Salem, NH
- Director of Community Support Programs, 1997-2000
- Director of Clinical Services, Community Support Programs, 1995-1997
- State Psychiatric Hospital Liaison 1990-1995
- Director of Outpatient Support Services, 1993-1995
- Clinician, Community Support Services, 1990-1993
- Case Manager, Community Support Services, 1987-1990
- Residential Manager, Adolescent Treatment Facility, 1985-1987

Publications
- Finnerty, M, Rapp, C, Bond, G, Lynde, D, Ganju, V, Goldman, H, "The State Health Authority Yardstick (SHAY)", Community Mental Health Journal, (2009) Vol. 45,(3): 228-236
- Woltmann EM, Whitley R, McHugo GJ, Brunette M, Torrey WC, Coots L, Lynde D, Drake RE. "The Role of Staff Turnover in the Implementation of Evidence-Based Practices in Mental Health Care", *Psychiatric Services, (*2008) Jul; 59 (7): 732-7
- Becker, D., Lynde, D., Swanson, S., "Strategies for State-Wide Implementation of Supported Employment: The Johnson & Johnson—Dartmouth Community Mental Health Program" *Psychiatric Rehabilitation Journal* 31 (2008) pp. 296 – 299
- Drake, RE, Merrens, MR, Lynde, DW (eds), Evidence-Based Mental Health Practice: A Textbook, Norton, NY, NY (2005)
- Drake RE, Essock SM, Shaner A, Carey K, Minkoff K, Kola L, Lynde D, et al. "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness" *Psychiatric Services* 52 (2001): 469–475.
- Mueser K, Torrey W, Lynde D, et al. "Implementing Evidence-Based Practices for People with Severe Mental Illness" *Behavior Modification* 27 (2003): 387 – 411.
- Torrey WC, Lynde D, Gorman P: "Promoting the Implementation of Practices That are Supported by Research: The National Implementing Evidence-Based Practice Project" *Child and Adolescent Psychiatric Clinics of North America*, 14 (2005): 297 – 306

Professional Licensure

- Licensed Independent Clinical Social Worker, State of New Hampshire, 1994-Present



Piper Suzanne Meyer-Kalos, Ph.D., LP

Education and Licensure

Minnesota Licensed Psychologist (#LP5617)	**April 30, 2013**
North Carolina Licensed Psychologist and Health Services Provider Psychologist (#3277)	**October 2, 2006**

Postdoctoral Fellowship — **2003- 2005**
National Research Service Award (NRSA) Fellowship, Mental Health and Substance Abuse Systems and Services, Cecil G. Sheps Center for Health Services Research, University of North Carolina
Chapel Hill, North Carolina

Doctorate, Clinical Rehabilitation Psychology — **1997- 2003**
Purdue University School of Science, Indianapolis, IN
Dissertation: The cognitive factor of the PANSS: A confirmatory factor analysis and related cognitive correlates

Master of Science, Clinical Rehabilitation Psychology — **1999**
Purdue University School of Science, Indianapolis, IN
Master's Thesis: The impact of atypical antipsychotics on vocational outcomes

Bachelor of Arts, Psychology, Minor: Sociology — **1995**
DePauw University, Greencastle, IN

Professional Appointments/Employment

Director — 2013 - current
Minnesota Center for Chemical and Mental Health (MNCAMH), St. Paul, MN
Director of a statewide center of excellence to provide training, research, and resources for emerging and existing practitioners and to build and sustain excellence in the delivery of mental health services. Coordinating and conducting mental health and addictions research and workforce

development, acquiring external support, connecting the Center to the community providers, establishing center infrastructure, and supervising graduate research assistants.

Research Assistant Professor 2005 - 2013

UNC-CH Department of Psychology, Chapel Hill, NC

Research coordinator for a clinical psychology lab focused on psychosocial treatment for schizophrenia and the assessment of social cognition in schizophrenia. Supervised undergraduate lab staff, provided clinical supervision for research projects, participated in development of grants, and development of psychosocial curriculum. Developed community alliances with county/state agencies to recruit for research studies.

Research Projects:

- Recovery After Initial Schizophrenia Episode (RAISE). Co-developed an individual therapy for people with first episode psychosis, and conducted training, ongoing clinical supervision, and fidelity evaluations for 13 national sites.
- The Farm at Penny Lane. Coordinating the development of a garden/farm program for persons with mental health disorders. Developing program evaluation measures to evaluate nutrition, weight, mental health, and activity level.
- Positive Living. Adapted a positive psychology treatment for people with schizophrenia and conducted pilot studies with persons with schizophrenia. Utilized pilot research in recent grant application.
- Social Cognition and Interaction Training (SCIT). Project coordinator for a treatment aimed at improving social cognition for persons with schizophrenia.
- An investigation of Group Cognitive Behavioral Therapy (CBT) compared to Supportive Therapy for Auditory Hallucinations. Project coordinator and group facilitator.

Postdoctoral Fellowship, Cecil G Sheps Center, University of North Carolina 2003- 2005
Chapel Hill, North Carolina

Research Assistant, Mental Illness and Research Education and 2002 - 2003
Clinical Center (MIRECC), Veteran's Administration,
Baltimore, Maryland

Intensive Case Manager, CREOKS Mental Health Services, 1995 - 1997
Oklahoma State Certified Case Manager for Creek County.
Sapulpa, OK

Clinical Experience

Postdoctoral Fellowship, Department of Psychiatry, 2003 –2005
STEP Clinic, University of North Carolina, Chapel Hill, NC

- Provided manualized individual and therapy for adults with serious mental illness using Illness Management and Recovery and Graduated Recovery Intervention Program.

Clinical Psychology Intern, Serious Mental Illness Track — 2002 - 2003
University of Maryland School of Medicine,
Baltimore, MD (APA approved program)

- Provided individual therapy and case management in an urban community mental health center. Taught psychoeducational groups and social skills training groups. Participated in specialty rotations including sex offender's treatment clinic and mental health and substance abuse treatment program for federal pretrial and probation.

Practicum, LaRue Carter Hospital, — 2000 - 2001
Indianapolis, IN

- Adolescent Inpatient Unit. Therapist for adolescents on an inpatient unit with developmental disabilities, learning disabilities, medical disorders, and behavioral problems.

Practicum, Indiana Women's Prison, — 2000
dianapolis, IN

- Special Needs Unit and Indiana Women's Intake Unit. Provided group therapy on the Special Needs Unit. Conducted psychological evaluations including tests of intelligence, personality, and neuropsychology.

Practicum, Counseling and Psychological Services, IUPUI — 2000
Indianapolis, IN

- University counseling center. Provided individual and couples counseling including cognitive-behavioral therapy for persons aged 18 to 45.

Practicum, Veterans Administration — 1998 - 1999
Indianapolis, IN

- Provided group and individual psychotherapy for individuals with psychiatric disabilities. Population was primarily those with serious mental illness. Assisted in research projects.

Practicum, Veterans Administration, NIMH Research Project, — 1998
Indianapolis, IN

- Conduct assessment interviews for elderly depressed women, including SCID,

CES-D, Mini Mental Status, Coping, and Network Transactions.

Teaching and Training Experience

Instructor, University of Haifa, Israel, Social Cognition and Interaction Training (SCIT) and Positive Psychotherapy for people with schizophrenia. — September 2011

Consultation and Training, State of Missouri, Illness Management and Recovery for an inpatient forensic unit. — 2011 - 2013

Consultation and Training, University of Medicine and Dentistry of New Jersey, for the state of New Jersey, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies for IMR — 2007 – 2013

Consultation and Training, Minnesota Department of Human Services, Illness Management and Recovery, Supervisor's training for IMR, CBT strategies For IMR, IMR Clinical Competency Scales — 2006 – 2013

Consultation and Training, North Carolina Evidence-Based Practice Center, Wellness Management and Recovery — 2004 – 2007

Recitation Instructor, Introductory Psychology, IUPUI, Indianapolis, IN — 2002 - 2002

Awards

Clinical Rehabilitation Psychology Outstanding Master's Student Award — 1999
IUPUI, Indianapolis, IN

Rehabilitation Services Administration Fellowship — 1997 -1998
IUPUI, Indianapolis, IN

Outstanding Service Award — 1996
CREOKS Mental Health, Sapulpa, OK

Professional Organizations

American Psychological Association — 2008-2009
Association of Behavioral and Cognitive Therapy — 2007-current

Publications

Parks, A., Kleiman, E. M., Kashdan, T. B., Hausmann, L. R. M., **Meyer, P. S.**, Day, A. M., Spillane, N. S., & Kahler, C. W. (in press). Positive Psychotherapeutic and Behavioral Interventions. In Jeste and Palmer, (eds.) Positive Psychiatry, A Clinical Handbook. American Psychiatric Press.

Buck, B., Ludwig, K., **Meyer, P. S.**, Penn, D. (2014). The use of narrative sampling in the assessment of social cognition: The Narrative of Emotions Task (NET). Psychiatry Research, 217(3), 233-239.

Meyer, P. S., Johnson, D., Parks, A., Iwanski, C., Penn, D. (2012). Positive living: A pilot study of group positive psychotherapy for people with schizophrenia. Journal of Positive Psychology, 7(3), 239-248.

Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2011). Loving-kindness meditation for schizophrenia. Schizophrenia Research, 129(2/3), 137-140.

Meyer, P. S. & Mueser, K. T. (2011). Resiliency in persons with severe mental illness. In Southwick, Litz, Charney, Friedman, (eds.) Resilience and Mental Health: Responding to challenges across the lifespan. Cambridge University Press.

Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D. J., **Meyer, P. S.**, Penn, D. L. (2010). Upward spirals of positive emotions counter downward spirals of negativity: Insights from the broaden-and-build theory and affective neuroscience on the treatment of emotion dysfunctions and deficits in psychopathology. Clinical Psychology Review, 30(7), 849-864.

Meyer, P. S., Mueser, K. T., Gingerich, S. (2010). A guide for the implementation and clinical practice of Illness Management and Recovery for people with schizophrenia. In Rubin, A. and Springer, D. (eds.) Psychosocial treatment for schizophrenia. John Wiley & Sons.

Penn, D. L., Keefe, R. S., Davis, S. M., **Meyer, P. S.**, Perkins, D. O., Losardo, D., Lieberman, J. A., (2009). The effects of antipsychotic medications on emotion perception in patients with chronic schizophrenia in the CATIE trial. Schizophrenia Research, 115 (1), 17-23.

Penn, D. L., **Meyer, P. S.**, Evans, E., Cai, K., Wirth, R. J., Burchinal, M. (2009). A randomized controlled trial of group cognitive behavior therapy versus enhanced supportive therapy for auditory hallucinations. Schizophrenia Research, 109 (1-3), 52-59.

Johnson, D.J., Penn, D.L., Fredrickson, B., Kring, A., **Meyer, P.**, Brantley, M. (2009). Loving-kindness meditation to enhance the psychological recovery of individuals with persistent negative symptoms of schizophrenia: A case study. Journal of Clinical Psychology, 65(5), 499-509.

Johnson, D. P., Penn, D. L., Bauer, D. J., **Meyer, P.**, Evans, E. (2008). Predictors of the therapeutic alliance in group therapy for individuals with treatment-resistant auditory hallucinations. British Journal of Clinical Psychology 47(2), 171-183.

Morrissey, J. P., **Meyer, P. S.**, Cuddeback, G. (2007). Extending ACT to criminal justice settings: Origins, evidence, and future directions. Community Mental Health Journal 43(5), 527-544.

Meyer, P.S. & Morrissey, J. P. (2007). Assertive community treatment, intensive case mangement, and the paradox of rural mental health services. Psychiatric Serivces 58(1), 121-127.

Cuddeback, G., Morrissey, J. P., **Meyer, P. S.** (2006). How many assertive community treatment teams do we need? Psychiatric Services 57(12), 1803-1806.

Mueser, K. T., **Meyer, P. S.**, Penn, D. L., Clancy, R., Clancy, D. M., Salyers, M. P. (2006). The Illness Management and Recovery program: Rationale, development, and preliminary findings. Schizophrenia Bulletin, 32, S32-S43.

Evans, J. D., Bond, G. R., **Meyer, P. S.**, Kim, H. W., Lysaker, P. H., Gibson, P. J., Tunis, S. (2004). Cognitive and clinical predictors of success in vocational rehabilitation in schizophrenia. Schizophrenia Research, 70(2-3), 331-342.

Bond, G. R., Kim, H. W., **Meyer, P. S.**, Gibson, P. J., Tunis, S., Evans, J. D., Lysaker, P., McCoy, M. L., Dincin, J., Xie, H. (2004). Response to Vocational Rehabilitation During Treatment with First- or Second-Generation Antipsychotics. Psychiatric Services, 55, 59-66.

Salyers, M. P., Evans, L. J., Bond, G. R., **Meyer, P. S.** (2004). Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people with severe mental illness: Clinician perspectives. Community Mental Health Journal, 40, 17-31.

Meyer, P. S., Bond, G. R., Tunis, S. L., McCoy, M. L. (2002). Comparison between atypical and traditional antipsychotics in work status for clients in a psychiatric rehabilitation program. Journal of Clinical Psychiatry, 63, 108-116.

Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., Clements, C.A. & Marks, K.A. (2001) Psychosocial correlates of childhood sexual trauma in schizophrenia. Psychiatric Services, *52*, 1485-1488.

Lysaker, P.H., **Meyer, P.S.**, Evans, J.E., & Marks, K.A. (2001). Neurocognitive correlates of self reported sexual abuse in schizophrenia spectrum disorders. Annals of Clinical Psychiatry, *13*, 89-92.

Bond, G.R. & **Meyer, P. S.** (1999). The role of medications in the employment of people with schizophrenia. Journal of Rehabilitation, 65(4), 9-16.

Presentations

Meyer, P.S., (July 2011). Positive Living: A pilot study of group positive psychotherapy for people with schizophrenia. Symposium at Second World Congress on Positive Psychology.

Meyer, P.S., Johnson, D., Penn, D. L. (November 2009). Positive living: An adaptation of group positive psychotherapy for people with psychotic disorders. Symposium at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D.L., Roberts, D., Koren, D. (November 2008). The relationship between metacognition, social cognition, and social functioning in schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Johnson, D., Penn, D., **Meyer, P.**, Fredrickson, B., Kring, A., Brantley, M. (November 2008). Loving kindness group meditation for the negative symptoms of schizophrenia. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D.L., Evans, E., Cai, K., Burchinal, M. (November 2007) A randomized controlled trial of group CBT and supportive therapy for auditory hallucinations. Poster presentation at the Association for Behavioral and Cognitive Therapies.

Meyer, P.S., Penn, D., Mueser, K., Waldheter, E. (April 2005). A pilot study of illness management and recovery for persons with psychotic disorders. Poster presentation at the International Congress on Schizophrenia Research.

Meyer, P.S. & Morrissey, J. P. (June 2004). Overlooked Obstacles in Disseminating Assertive Community Treatment in Rural Settings. Poster presentation at the NIMH Trainees Research Conference.

Meyer, P.S., Gearon, J., Bellack, A., & Brown, C. (March 2003). The Relationship Between Traumatic Life Events and Posttraumatic Stress Disorder in Substance Abusing Women with Schizophrenia. Poster presentation at the International Congress on Schizophrenia Research.

Bond, G.R., **Meyer, P.S.,** Kim, H., Marks, K. & Tunis, S.L. (February 2001). The promise of new antipsychotics and psychiatric rehabilitation for improving work outcomes: Why haven't state mental health systems embraced best practices? Oral presentation at the NASMHPD Eleventh Annual Conference on State Mental Health Agency Services Research, Program Evaluation.

Kim, H.W., Tunis, S.L., Bond, G.R., Marks, K.A., & **Meyer, P.S.** (2001). Psychiatric Symptoms & Adverse Events Commonly Reported During Antipsychotic Treatment for Individuals with Schizophrenia Participating in Psychiatric Rehabilitation Programs. Poster presentation at the Annual Convention of the American Psychiatric Association.

Lysaker, P.H., Evans, J.D., Kim, H.W., Marks, K.A., **Meyer, P.S.**, Tunis. S.L., & Bond, G.R. (2001). Symptoms and work performance in schizophrenia. Poster presentation at the International Congress of Schizophrenia.

Meyer, P. S., Kim, H. W., Bond, G. R., Tunis, S., McCoy, M., & Dincin, J. (October, 2000). Impact of Antipsychotic Medications on Vocational Outcomes for Persons with

Schizophrenia. Oral presentation at the MRI/UPENN Rehabilitation and Research Training Center 4th Biennial Research Seminar on Work.

Meyer, P., Bond, G. R., Herbeck, D., McCoy, T., and Rowan, D. (May 1999). The promise of newer antipsychotics: Implications for social and vocational outcomes. Workshop presented at International Association of Psychosocial Rehabilitation Services. Minneapolis, MN.

Meyer, P. S., Bond, G. R., McCoy, T., Herbeck, D., Rowan, D., and Tunis, S. (April, 1999). The influence of atypical antipsychotics on work outcomes. Poster presented at the International Congress on Schizophrenia Research, Santa Fe, NM.

Unpublished Manuscripts

Meyer, P. S. and Morrissey, J. P. (2004). Assertive community treatment in North Carolina: Implementation status and training needs. Report submitted to North Carolina Science to Service, Research Triangle Park, NC.

Bond, G., **Meyer, P.**, Rollins, A., McCoy, M., Herbeck, D., and Rowan, D. (1998). The impact of atypical antipsychotics on vocational outcomes in a psychiatric rehabilitation agency. Reported submitted to Eli Lilly, Indianapolis, IN.

References Available upon Request

Curriculum Vitae

DELBERT GAIL ROBINSON, M.D.

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

PROFESSIONAL EMPLOYMENT AND HOSPITAL APPOINTMENTS :

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

Glen Oaks, NY
Research Psychiatrist

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER ACADEMIC APPOINTMENTS:

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

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

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

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

BOARD CERTIFICATION:

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

PROFESSIONAL SOCIETY MEMBERSHIP:

American Psychiatric Association
International Early Psychosis Association
American College of Neuropsychopharmacology

AWARDS AND HONORS

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

OTHER PROFESSIONAL ACTIVITIES

JOURNAL REVIEWER

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

GRANT REVIEWER

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

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

Peer Review Committee, Schizophrenia Trials Network (NIMH)

Ontario Mental Health Foundation

The Netherlands Organisation for Health Research and Development

Deutsche Forschungsgemeinschaft (DFG) German Research Foundation

Feinstein Institute for Medical Research

National Committees

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

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

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

Texas Medication Algorithm Project

National Workshops

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

New York State Committees

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

Hospital Committees

Long Island Jewish Research Committee

Quality Assurance Committee, Hillside Research Department

Protocol Review Committee, Hillside Research Department

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

RESEARCH

PRINCIPAL INVESTIGATOR (FUNDED STUDIES)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SITE PRINCIPAL INVESTIGATOR

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

DIRECTOR

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

CO-DIRECTOR

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

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

CO-PRINCIPAL INVESTIGATOR

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

CO-INVESTIGATOR

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

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

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

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

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

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

CONSULTANT

Educational Material for Geriatric Psychopharmacology: Phase I (Small Business Innovation Research Program)
7/96 - 12/96

Educational Material for Geriatric Psychopharmacology: Phase II (Small Business Innovation Research Program)
11/00 – 4/05

A New Scale to Assess Psychopathology in Schizophrenia (NARSAD)
6/01 – 11/05

BIBLIOGRAPHY

ORIGINAL COMMUNICATIONS IN REVIEWED JOURNALS:

Akiskal HS, King D, Rosenthal T, Robinson D, Scott-Strauss A: Chronic depressions Part I. Clinical and familial characteristics in 137 probands. Journal of Affective Disorders

3:297-315, 1981.

Robinson DG and Spiker DG: Delusional depression: A one year follow-up. Journal of Affective Disorders 9:79-83, 1985.

McGrath PJ, Robinson D, Stewart JW: Atypical panic attacks in major depression. American Journal of Psychiatry 142:1224, 1985.

Ryan ND, Puig-Antich J, Ambrosini P, Rabinovich H, Robinson D, Nelson B, Iyengar S, Twomey J: The clinical picture of major depression in children and adolescents. Archives of General Psychiatry 44:854-861, 1987.

Ryan NC, Puig-Antich J, Rabinovich H, Ambrosini P, Robinson D, Nelson B, Novacencko H: Growth hormone response to desmethylimipramine in depressed and suicidal adolescents. Journal of Affective Disorders 15:323-337, 1988.

Wager S, Robinson D, Goetz R, Nunes E, Gully R, Quitkin F: The cholinergic induction test in atypical depression - A pilot study. Sleep Research 17, 1988.

Robinson D, Bailine S, Lieberman J: Dysphoria associated with methylphenidate infusions. American Journal of Psychiatry 145:1321-1322, 1988.

Glick ID, Schooler NR, Severe J, Weiden P, Robinson D: Depressive symtpomatology, negative symptoms and extrapyramidal symptoms (EPMS) in acute treatment response and short term outcome. Schizophrenia Research 2: 204, 1989.

Wager S, Robinson D, Goetz R, Nunes N, Gully R, Quitkin F: Cholinergic REM sleep induction in atypical depression. Biological Psychiatry 27:441-446, 1990.

Walsleben J, Robinson D, Lemus C, Hackshaw R, Norman R, Alvir J: Polysomnographic aspects of obsessive-compulsive disorder. Sleep Research 19: 177, 1990.

Robinson D, Mayerhoff D, Alvir J, Lieberman J: Mood responses of remitted schizophrenics to methylphenidate infusion. Psychopharmacology 105:247-252,1991.

Lemus CZ, Robinson D, Kronig M, Cole K, Lieberman JA: Behavioral responses to a dopaminergic challenge in obsessive-compulsive disorder. Journal of Anxiety Disorders 5: 369-373, 1991.

Levy DL, Smith M, Robinson, D, Jody D, Lerner G, Alvir J, Geisler SH, Szymanski SR, Gonzalez A, Mayerhoff DI, Lieberman JA, Mendell NR: Methylphenidate increases thought disorder in recent onset schizophrenics, but not in normal controls. Biological Psychiatry 34: 507-514, 1993.

Robinson D, Woerner M, Koreen AR, Siris SG, Chakos M, Alvir J, Mayerhoff D, Lieberman J: First-Episode schizophrenia and depression - Reply (Letter). American Journal of Psychiatry 152: 476-477, 1995.

Robinson D, Wu Houwei, Munne R, Ashtari M, Lerner G, Koreen A, Cole K, Bogerts B: Reduced caudate nucleus volume in obsessive-compulsive disorder. Archives of General Psychiatry 52: 393-398, 1995.

Greist JH, Jenike MA, Robinson D, Rasmussen SA: Efficacy of fluvoxamine in obsessive-compulsive disorder: results of a multicentre, double blind, placebo-controlled trial. European Journal of Clinical Research 7: 195-204, 1995.

Robinson D, Woerner M, Pollack S, Lerner G: Subject Selection biases in clinical trials: Data from a multicenter schizophrenia treatment study. Journal of Clinical Psychopharmacology 16: 170-176, 1996.

Strakowski SM, Flaum M, Amador X, Bracha HS, Pandurangi AK, Robinson D, Tohen M: Racial differences in the diagnosis of psychosis. Schizophrenia Research 21: 117-124, 1996.

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Key Personnel

Name	Job Title	Salary	% Paid from this Contract	Amount Paid from this Contract
Jamie Fairstone	Education Coordinator	$40,000	5%	$2,000
William Keller, MD	Director, First Episode Service	$224,995	2.5%	$5,625